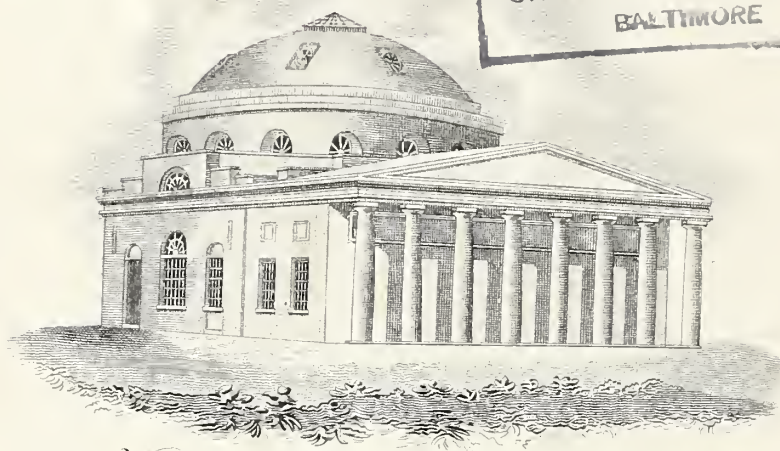






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## MATERNAL CARE IN MICHIGAN\*

### A Progress Note

ALEXANDER M. CAMPBELL, M.D.†

GRAND RAPIDS, MICHIGAN

As chairman of your Maternal Health Committee it becomes my privilege to report to you, briefly, some of the preliminary results of our study of maternal care. In making this report it seems desirable, first, to indicate those considerations which prompted the undertaking and to review, also, the general character of the work.

Just why should the Michigan State Medical Society and its Maternal Health Committee be interested in and wish to make a study of the subject covered by the broad title "Maternal Care in Michigan"? The answer to this question is obvious, I think, to all who are interested in the ultimate aims and goals of medical science.

Self-examination (and self-criticism if there be need for criticism) is a sensible, worth-while procedure and an occasional stock-taking of our work and of the results of our work, if straightforwardly made, can scarcely fail to be beneficial both to us and to our patients. There may be among us those who feel no need of such a general stock-taking. There are others among us who sincerely believe that no harm and some good is more than likely to come from a perfectly candid review of the care that is given our pregnant women.

There are, however, other and somewhat more cogent reasons why we, as medical men, should be interested in the quality of maternal treatment that is actually afforded the parous women in this State. All of you are familiar with the results of the many

studies which are appearing with increased frequency regarding the excessive—or apparently excessive—maternal mortality in this country. The reports from the U. S. Children's Bureau, the report of the New York Academy of Medicine, and the numerous reports from State Maternal Health Committees, such as our own, can scarcely be ignored by any medical group in this country. It is not my purpose to argue the pros and cons of the findings of investigations on preventable maternal deaths. It is my view, however, that we can ill afford to close our ears and minds to the plainly audible demand of American mothers for the best that can be had in maternal care.

It was with these and other considerations in mind that our Maternal Health Committee, with the aid of the U. S. Public Health Service, undertook what we believe to be an entirely new and a different type of study of the maternity problem. Heretofore, the maternal problem has usually been approached by intensive investigations of deaths charged to maternal causes; I can give numerous examples of studies in which Maternal Health Committees, such as ours, have investigated every maternal death and

\*Delivered before the Michigan State Medical Society at Grand Rapids, Michigan, September 28, 1937. This paper represents a preliminary and provisional report of a study on Obstetric Practices which is a cooperative investigation of the Maternal Health Committee of the State Medical Society and the Division of Public Health Methods, National Institute of Health, U. S. Public Health Service. The study is supported by grants from the Works Progress Administration and forms a part of the National Health Inventory.

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published figures showing that such and such a proportion of deaths was preventable, and preventable for such and such reasons. While this type of work is undoubtedly of value and obviously brings to light facts of importance in the broad problems of obstetric practices, it seemed to us that only a very limited view of major aspects of the problem would or could be afforded by investigations of maternal deaths alone. It seemed clear to us that entirely satisfactory information on the quality of maternal service must include just as careful study of women who had babies but who did not die. It did not seem entirely fair to study only the fatal cases without also hearing the evidence for successful cases.

There are, in Michigan, some 85,000 births every year and out of this number over 400 women die from some cause attributable to childbirth. While 400 mothers die, over 84,600 live; while many women undoubtedly have inadequate medical care, many more must have the finest kind of care. Considerable discussion of this question only served to make us more certain that we were actually taking a correct view. The more thought we gave to the problem, the more certain we became that the essence of the whole question, about which there has been and is still so much talk, is not confined to maternal deaths but must include the whole of obstetrics as actually practiced. Certainly it is reasonable to suppose that a much fairer cross section of obstetric practices would be obtained from a study of all cases rather than of only the cases that died. Furthermore, it must be apparent that a study of mothers who lived would furnish important information as to why some mothers die. Accordingly, we undertook this study. It is only fair, I think, to say that our work probably has been misunderstood in some quarters. Perhaps we are wrong in our judgment. As yet, however, we do not think so, and the results of our really arduous labors must, in the end, speak for themselves.

The plan of the obstetric practice study may be outlined briefly as follows: Copies were first made of the birth certificates for all babies born in the State during the period January 1 to March 31, 1936. These were then assembled to bring together all of the certificates signed by the same doctor, midwife, or other signer of the birth record. A blank obstetric history form cor-

responding to each birth certificate was next sent to the person signing the certificate with the request that he fill out the form, which covered details concerning the pregnancy, labor and the puerperium. These filled-in forms, plus the copies of birth certificates and death certificates for mothers and infants who died, make up the data on which the study is based.

During the period covered by the study, the first quarter of 1936, a total of about 21,000 births were registered in the State. Although an obstetric history form was sent out to correspond to each of these births, the number of filled-in forms which were returned equalled only one-half of this number or approximately 10,000 records. This number of records obviously is a very adequate sample of cases, provided, of course, that there is no bias in the kind of cases for which records were supplied.

The first job which faced us in the study consisted, therefore, in a very careful examination of the records to determine whether or not there was such a bias. Thus if the records for only certain classes of women were returned, or if only certain groups of doctors filled in their forms, it is apparent that the study would represent only a selected group of women or birth attendants and fail to give a general picture of facts for the State as a whole. The results of the examination of the records from this viewpoint are very satisfactory. It is clear that there is no very serious misrepresentativeness of either parous women or of birth attendants. This part of the study, and it is a very important part, is now nearly complete but I shall not discuss with you the details which we were forced to consider. It is sufficient to say merely that almost exactly 50 per cent of the birth attendants filled in and returned their forms and that almost exactly 50 per cent of the forms sent out were returned. The proportion of records available for the study appears fairly representative for women living in the country and in cities of different size, for women delivered in the home and in hospitals, and for doctors who have a small and those who have a large obstetric practice. There appears to be no tendency for the doctors to fail to return records for those cases which did not have a favorable outcome. The maternal death rate, the infant death rate, and the stillbirth rate appear to be approximately the same among the cases

for which we have records as among those for which we do not have detailed histories. There seems to be no serious bias with respect to the economic status as measured by occupation of the husband. Taken all together these findings are very encouraging. They mean, essentially, that the facts which we find for the 10,000-odd cases represent the facts for all women in the state. They mean, further, that we probably have a reasonably fair sample of obstetric histories from which to judge actual practices in the state as a whole.

With this much of the preliminaries cleared away, let me give a few of the findings that are emerging from the mass of data which has been collected. Let me tell you what we have found in answer to such questions as these: What proportion of our maternity cases is unattended except by some member of the family or by a neighbor or friend? What proportion of our maternity cases gets adequate prenatal care as judged by present day standards? What differences are there, if any, in the care given our well-to-do mothers and our poor mothers? Taking the pregnant women in the state of Michigan as a whole, are certain groups or classes of women getting very little or no medical care at the time of delivery of their babies? These questions, and many more, we can answer with reasonable accuracy from the results of the study. And I might add, we believe that these are sensible questions for which we should have reasonably correct answers.

According to the records available for our study the 21,000 births registered during the first quarter of 1936 were attended by about 3,200 different persons. Of these 3,200 attendants, 96 per cent were doctors of medicine, 2 per cent were doctors of osteopathy and 2 per cent were midwives, neighbors or friends of the pregnant women. It is apparent, therefore, that, so far as this state is concerned, doctors attend the births of most of the babies.

In exploring the question of birth attendant a little further, we may make inquiry concerning other pertinent facts. There are listed in the Michigan section of the Directory of the American Medical Association about 6,000 doctors of medicine. It follows, therefore, that about half of these are engaged in obstetric practices, since nearly 3,100 of them delivered at least one baby

during the first quarter of 1936. These 3,100 doctors attended approximately 20,000 births or, on the average, each attended about 7 women. Obviously, some actually attended more than 7 and some less than 7, and it is of some interest to inquire as to how the 20,000 births were distributed among the 3,100 physician attendants. We find that about half of these men attended less than five births, or a total of 1,500 attendants delivered less than 3,500 babies. The other 1,500 attendants delivered 18,000 babies. Expressed a little differently, nearly 85 per cent of the obstetric work in the state is handled by a small group of 1,500 men. Since these 1,500 men represent only one-fourth of the doctors practicing in the state, we note that one-fourth of all the doctors deliver 85 per cent of all the babies.

There are in Michigan today two large medical schools. A fairly large proportion of their graduates remain and practice in this state. What per cent of our babies are delivered by them? Our findings show that almost exactly the same number of babies are attended at birth by graduates from each of these two schools. When totaled we find that more than 50 per cent of all babies are delivered by men trained in our own two schools.

Extending our inquiry still further regarding the characteristics of birth attendants, we ask what proportion is qualified as specialists and by this criterion considered particularly trained for obstetric work. The study shows that one-sixth of the confinements are attended by persons who have listed themselves in the Directory of the American Medical Association as either specialists or partial specialists in obstetrics or gynecology.

Let me turn now to another aspect of the study. It is generally believed today that an essential part of adequate medical care of the parous woman consists of certain more or less standardized procedures which make up the prescribed technics of prenatal care. At the present time, there may be some difference of opinion as to just what constitutes adequate prenatal care but in general it must be admitted that the simple test for albumin, the determination of blood pressure, and the measurement of the pelvis, constitute the minimum of service procedures which should be afforded every pregnant woman. In addition to



these, most physicians would demand that the weight of the puerperal woman be checked, that abdominal examinations be made, that at least one physical examination be given, and that the pregnant woman should be apprised of a certain few danger signals. Those of us who wish to define adequate prenatal care in terms of somewhat more extensive service insist that all of the above technic is essential and add that it should be carried out at frequent intervals. The most rigorous standards of such care provide that these procedures should be carried out once a month during the first seven months of pregnancy, twice during the eighth month and once a week during the last month. Most of us will agree, I think, that prenatal care is not merely a matter of textbook theory but that it should be a practical actuality. It is of considerable interest to inquire, therefore, what light our study will throw on the actualities of prenatal care as given our parous women.

For purposes of classifying the records submitted to us, it is not possible, nor is it necessary, to make too hard and fast a definition of prenatal care. Thus we have found it advantageous to group our 10,000-odd cases into three subdivisions which we have called (1) the adequate care group, (2) the inadequate care group, and (3) the no prenatal care group. According to our simple arbitrary classification, women included in the first group were those who had, during pregnancy, seen a doctor at least five times (average six). In addition, these women received, on the average, four urinalyses, four blood pressure tests, two abdominal examinations, were weighed 3 times, had had a pelvic measurement for this or some other pregnancy, and who, generally, had had some prenatal instructions from a doctor or nurse. Women included in the second prenatal care classification were those who had seen a doctor four or fewer times and averaged only two visits during the whole of the pregnancy period. These women averaged only two urinalyses, two blood pressure tests, one weighing and one abdominal examination. Many of them received no prenatal instruction and relatively few of them had a pelvic measurement. The third classification of women needs no description. Women in this group received essentially no prenatal care whatsoever. Most of them

were seen for the first time by the doctor when they were in labor.

This classification of the 10,000 cases may not be, we realize, entirely satisfactory, but it does afford a rough grouping which should give a general view of the distribution of prenatal care for women in the state as a whole. Certainly a somewhat striking view of the distribution is obtained when I say that only 53 per cent of our cases are included in the first group, the one which we have called, for present purposes, the adequate prenatal care group. Twenty-six per cent are included in the second group. Twenty-one per cent, or slightly more than 2,100 women, fall into the class defined by the fact that they received essentially no prenatal care. These, we presume to think, are striking and important findings. One out of every five pregnant women in this state does not see a doctor until labor actually begins. Almost half, 47 per cent, of our pregnant women fail to receive prenatal care that can be considered satisfactory by even low standards.

The next questions which we asked of our records were these: Is the lack of prenatal care evenly distributed among pregnant women? Do rich and poor alike fail to get prenatal care? Are there differences, in this respect, between women living in urban and in rural districts? Are primiparæ and multiparæ alike in getting or failing to get adequate care during the antenatal period? Do certain groups of doctors differ with regard to this important question? Obviously, I cannot give you detailed answers to these questions. It must suffice to say here that very marked and significant differences do appear in the amount and kind of prenatal care that is received by different groups of the population. Among the women in comfortable or moderately comfortable economic circumstances, two-thirds receive what we have called adequate prenatal care, while among those on relief, only one-fourth receive this type of care. Only one woman in 10 in the upper income groups receives no prenatal care, while over four women in ten among those on relief receive no care. In general, a higher proportion of women living in rural districts fail to receive adequate medical attention than do those living in urban centers. Multiparous women receive less care than primiparous, multiparous



women living in rural districts being exceptionally lacking in adequate care.

During the past few years there has been a great deal of emphasis placed on this question of prenatal care, and most of us subscribe to the view that medical attention and supervision during pregnancy are a necessary part of sound obstetric practice. In some respects at least, most of us do not demand proof, outside of our general experience, that prenatal care is actually sound as a preventive measure. There are, however, those who believe that too much emphasis has been placed on this aspect of maternal care and who believe that good obstetric work at labor and delivery are sufficient. Furthermore, a number of studies on the value of prenatal care have been made and the results of these studies do not, in general, show great advantage in favor of the woman who receives extensive medical supervision during pregnancy. Very careful study of this problem reveals, however, that a good many factors must be considered in evaluating accurately the advantages of good prenatal care.

What can the present study contribute that will be of use in attempts to obtain practical answers to the many questions which are raised regarding the real value of prenatal care? What specific results, which may be called good, are obtained when complete prenatal care is given and what specific results, which may be called harmful, are obtained when adequate care is not given? A minimum description of the results of any kind of medical care can be expressed in terms of whether or not patients live or die. The study of our records from this viewpoint is not complete, but I can say that some evidence thus far available indicates that satisfactory maternal care during pregnancy is associated with lower death rates.

A more descriptive and perhaps a much better estimate of the value of prenatal care should be obtained, we think, by considering injuries, disability and general morbidity rather than deaths. The study of the records from this viewpoint is now only partially completed, but it is possible to say that evidence is accumulating which indicates that harmful and injurious complications of pregnancy, labor, delivery and the puerperium are higher among women who do not receive sufficient medical attention during the prenatal period.

There are, of course, many other findings which are already clearly brought out in our review of the records. At this time, however, most of the results obtained are in the nature of isolated facts which must be correlated and interpreted in the light of the findings as a whole. Your committee feels, after going over the detailed results now available, that much information of interest and of value in understanding our local problem will be derived from the study. These details you will want to consider and evaluate in much less cursory fashion than would be possible during such a presentation as I have given here. In this connection, I may say that a complete report of the work is now in process of preparation. From the report, which will contain full details and our considered interpretation of the meaning of our findings, it should be possible to derive practical suggestions directed towards better maternal care for the women of Michigan.

The Chairman and other members of the Committee on Maternal Health acknowledge the valuable services of Dr. Carroll E. Palmer of the United States Public Health Service, who has prepared the material for this preliminary report.

# THE OBSTETRIC FORCEPS AND THEIR USE\*

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From legendary midwifery of the primitive peoples to a more rational obstetrics based on a knowledge of anatomy and physiology was a long stride. Vast also was the change from mystic potions and medicinal concoctions to asepsis and antisepsis. Each century has seen revivals in obstetric interest. Each campaign has left its mark and, in general, this has been for the good of mankind. We are now passing through another era, which in many ways bears promise of being the greatest in obstetric history.

With every wave of enthusiasm come fads and fancies, here today and gone tomorrow unless they portend a real advance. Such trial and error frequently characterized medical advance, and, when associated with unbridled enthusiasm, has extracted unnecessary toll in human life and suffering. Contemporary obstetrics has its fads and fancies. Prominent examples are the present adventure in obstetric amnesia and analgesia and the experiment with so-called prophylactic, academic, or outlet forceps. This sailing of uncharted seas, this experimentation, plays an important part in obstetric progress. Prophylactic outlet forceps, like its principal instigator, obstetric analgesia, is on probation awaiting the verdict of accumulated experience and time.

Today prophylactic forceps occupy a prominent rôle in the theater of obstetric controversy. Obscured by its notoriety, however, are many important operations made possible by an understanding use of these instruments. Let us first look beyond the venture in outlet forceps to a consideration of the basic principles underlying the use of forceps in general.

One hundred and fifty years ago that great master of British midwifery, William Smellie, gave to medical science his "Rules for Using the Forceps." During the intervening years these rules have safely guided physicians in their use of forceps. The fact that these rules have undergone but little change since first enunciated 150 years ago, amply testifies to their inherent soundness. The foundation upon which the intelligent use of forceps is based is an understanding of the mechanism of labor, plus a thorough knowledge of both indications and contraindications. The mechanism of labor cannot be included within the scope of this paper, but the indications and contraindications will be presented in some detail. It is not

too much to expect that any physician contemplating future use of forceps should learn these fundamentals so thoroughly that they become immediately available whenever an operative delivery is necessary.

## Indications for Use of Forceps

In general it may be stated that any condition which interferes with the normal progress of labor may become an indication for forceps. More specifically these may be:

### A. *Faults in Forces:*

1. Inefficient contractions:
  - (a) Inertia.
  - (b) Exhaustion.

### B. *Abnormalities in Birth Canal:*

1. Mild or moderate pelvic contraction.
2. Resistant or muscular perineum.
3. Prominent spines.
4. Rigid coccyx.
5. Certain abnormalities of vagina and cervix (scars, etc.).

### C. *Faults in Child:*

1. Abnormal positions. Failure in rotation and/or flexion of fetal head.
2. Aftercoming head in breech presentations.
3. Large head.
4. Monsters—where destructive operation is not indicated.

### D. *Dangers Threatening Life of Mother:*

1. Heart disease.
2. Tuberculosis.
3. Etc.

### E. *Dangers Threatening Life of Child:*

1. Fetal heart rate below 100 and getting slower—or excessively fast.

Like all indications for forceps delivery, judgment plays an important part. This is particularly true in the interpretation of fetal heart rates. Intelligently used, forceps may save the life of an embarrassed child, but it must not be forgotten that many a child has been unnecessarily injured by hasty and forcible delivery for variation in fetal heart tones, which, after all, is often a relative indication.

2. Meconium in cephalic presentation.

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Not including the so-called prophylactic forceps it may be safely estimated that 75 per cent of all instrumental deliveries are due to insufficiency of the powers, usually a combination of fatigue and resistance of the perineum.

Whenever there is thought to exist an indication for forceps the logical procedure is to weigh this indication against any contraindications which may be present. By so doing, the problem of deciding whether we are dealing with a just and sufficient indication becomes a relatively simple matter. Since contraindications to the use of forceps are important, they are listed herewith:

### Contraindications to Use of Forceps

1. An undilated or imperfectly dilated cervix.
2. Severe cephalo-pelvic disproportion (provided, of course, some safer alternative is available).
3. Floating head.
4. Mentum posterior positions.

### *Dangers Incident to Forceps Delivery:*

1. For the Mother:
  - a. Hemorrhage.
  - b. Infection.
  - c. Trauma—deep tears.
2. For the Child:
  - a. Intracranial injury.
  - b. Asphyxia—compression of cord.
  - c. Palsies—brachial—facial.
  - d. Fractures.

The careful physician does not stop at this point in evaluating supposed indications for forceps, for certain requirements must also be fulfilled. Presupposing a thorough knowledge of their use and assuming that the indication has been weighed in the light of existing contraindications and found valid, it then becomes necessary to see that certain requirements are fulfilled.

### Requirements for Use of Forceps

1. The cervix must be dilated, or easily dilatable.
2. There must be no excessive cephalo-pelvic disproportion.
3. The membranes must be ruptured.
4. Bladder and bowel must be empty.
5. The child must present properly and the position must be known. This latter is important.

While thorough knowledge of the foregoing is essential and will go a long way toward keeping the physician out of trouble, it must not be assumed that this knowledge alone qualifies the physician as an obstetrician. There still remains experience which should be acquired under competent supervision. A difficult forceps delivery, to be competently performed, requires quite as

much judgment and practice as does the average abdominal operation.

From the foregoing it will be seen that the indications for forceps appear in their true light only when weighed against such contraindications as may also be present.

Keeping these fundamentals in mind, let us look into the status of forceps today. That real improvement has occurred is evidenced by the decrease in the number of high forceps operations and elimination of forceps applications to the floating head. This obsolete procedure is almost never indicated, and its passing may be attributed to a keener understanding of the birth process. It might point to greater discrimination in the management of labor were it not for evidence to the contrary. Whether the apparent improvement is neutralized by the present enthusiasm for outlet forceps remains to be seen.

The incidence of so-called midforceps (head at the level of the spines and unrotated) appears to have shown no great decline. While in part this may be attributed to the prevailing restlessness and urge for interference, it may also be due to the fact that inertia, malpositions, large babies and cephalo-pelvic disproportion continue to require interference. Situations demanding forceps delivery are bound to occur, and some of these will elude our best efforts at prenatal evaluation and rectification for a long time to come.

One cannot consider the question of forceps without specific mention of the much talked of posterior presentations. A cause for grave concern in some, it is little more than a slight deviation from normal in others. Given reasonable time, most posterior presentations—and I mean the vast majority—rotate around satisfactorily. Those that do not rotate anteriorly may deliver spontaneously as a posterior. A small minority fail either to advance or rotate, and therefore require assistance. This small group is best handled by manual rotation and forceps extraction. When manual rotation is not possible, deep bilateral episiotomy and extraction as a posterior is often less harmful than forceps rotation (Scanlon maneuver) followed by extraction. Delivery as a posterior is considered unorthodox but even so I sometimes prefer it to forceps rotation.

Another important use of the obstetric



forceps, which happily is becoming more widely used, is for the aftercoming head in breech presentations. General acceptance of this procedure is to be urged. The danger of birth trauma is unquestionably reduced by so doing. While almost any forceps will do, the Piper forceps, especially designed for this purpose, is to be recommended.

All of which logically brings us to a consideration of outlet forceps. What shall we, as practitioners, believe regarding this increasingly popular procedure? For years I have followed contemporary thought regarding this operation. I have tried to determine its merits and shortcomings. Anyone who has thoroughly scrutinized the subject must quickly recognize its origin as a natural sequence or by-product of the present well developed experiment in obstetric amnesia and analgesia. Now that drugging during labor appears to have passed the delirious stage there is reason to believe that outlet forceps will again become less a necessity and more an elective procedure, and it is from this viewpoint that its advantages and disadvantages should be considered. Briefly stated, these are:

### Prophylactic Forceps

#### *Advantages*

1. Shortens labor.
2. Reduces fatigue and exhaustion of mother.
3. Lessens maternal birth trauma.
4. Reduces fetal birth injuries.
5. Reduces fetal mortality.
6. Saves time for doctor.

#### *Disadvantages*

1. Increases manipulation, therefore sepsis.
2. Not nature's way, therefore undesirable.
3. Leads to more and more interference.
4. Greater danger of fetal injury.
5. Increases fetal mortality.
6. Unnecessary, meddling midwifery.

The value of conserving the mother's energy and lessening pain by lifting the fetal head over the perineum cannot be denied. Neither can we doubt that by reducing bombardment of the perineum by the fetal head we also lessen the danger of fetal asphyxia and intracranial injury. Furthermore, there exists no evidence that by so

doing the danger to either mother or child is in any way increased. But the operation harbors a potential danger which cannot be overlooked. Lured on by the ease and apparent harmlessness of the procedure, the once reliable physician quickly becomes a restless manipulator. Judgment and care give way to enthusiasm and aggressiveness. Indications for other operative procedures are found with increasing avidity and womanhood is apprised of a new obstetric technician. There appears to be no good reason for lifting the head over the perineum before the patient has been given reasonable opportunity to deliver spontaneously. Neither is there any logical excuse for unnecessarily prolonging the second stage of labor.

In evaluating the so-called prophylactic or outlet forceps, it is necessary to eliminate incidental factors which tend to color the picture. With more rational use of sedative drugs during labor the need for forceps delivery should decline. That it is a safe and useful procedure when carefully performed cannot be denied. There is no substitute for eutocia but not all women have easy labors. For those that do not, outlet forceps may be a real boon. Certainly it is safer than such substitutes as excessively prolonged second stage and/or oxytocics (pituirin, thymophysin, etc.). The operation is unquestionably abused but when applied with skill and judgment deserves a limited, but merited, place in contemporary obstetric practice.

In general the fundamental principles which have guided us in the past should continue to guide us in the future. While most women will deliver spontaneously if given reasonable opportunity, this should not prevent us from assisting and shortening the birth process, *provided* this can be done with *safety* and *benefit* to both mother and child. Because a procedure is new or presents a modern twist does not mean it should be condemned. Neither does it necessarily imply improvement. As in all things—so too in obstetrics—judgment and common sense should continue to be our sheet anchor.

# MODERN SURGERY OF THE BILIARY TRACT\*

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During the last fifteen years the improvement in the early diagnosis and treatment of gall-bladder disease is one of the outstanding features of the progress of medicine and surgery. This is due to improved methods of diagnosis, especially the Graham-Cole test, better surgical judgment, due to improved training and wider experience, improvement in surgical technic, and improved methods of preoperative and postoperative care. It is also due to the fact that the medical profession realize, more and more, that the diseased gall bladder is a detriment to the health of patients. In the general examination of patients we include an x-ray examination of the gall bladder in our routine group of physical, laboratory and x-ray examinations.

With the records of population showing an increase of people over fifty years of age, we must expect an increase in the incidence of gall-bladder disease. Therefore we must continue our vigilance in reducing the morbidity and mortality of this disease by early diagnosis and proper treatment.

## The Chronic Gall Bladder

Medical management is indicated in that group of cases of mild cholecystitis which have symptoms of gas distress, bilious headaches, sore mouth or bad taste in the mouth, indigestion, belching, slight or moderate upper abdominal distress, and with the Graham test showing impaired or poor function of the gall bladder without stones. With proper supervision of dietary habits, the use of a medium fat-free high-acid diet with the addition of dilute hydrochloric acid, the removal of all foci of infection, and proper elimination, these cases usually are greatly relieved.

However, if they are not improved under a good trial of this regime, as shown by their symptoms or the Graham test, they should be considered surgical.

All chronic gall-bladder cases which have severe symptoms, especially colic, and in which the Graham test shows either a functionless gall bladder or gallstones, are surgical. This will include all cases in which the diseased gall bladder is suspected as the focus of infection for heart disease, arthritis, and chronic pancreatitis with glycosuria.

In operations for chronic gall-bladder disease, I make a practice of removing the

TABLE I. RÉSUMÉ OF 100 CASES OF BILIARY DISEASE

November, 1936, to September, 1937

Male patients .....	12
Female patients .....	88
Youngest patient .....	29
Oldest patient .....	74
Average age .....	48
Average duration of symptoms.....	4¼ yrs.
Acute cases .....	22
Chronic cases .....	78
Cases with stones .....	82
Cases without stones .....	18
Cases with jaundice .....	9
Cases not jaundiced .....	91

### Acute Cases—22

Empyemas .....	13
Gangrenous cases .....	11
Perforated cases .....	2
Cases with hepatitis and pancreatitis .....	17
Cases with acute hemorrhagic pancreatitis....	2
Cases with stones .....	20
Cases without stones .....	2

### Chronic Cases—78

Cases with stones .....	62
Cases without stones .....	16
Cases with stones in ducts .....	17
Cases of carcinoma of gall bladder .....	1
Cases of carcinoma of pancreas .....	1
Cases of biliary cirrhosis .....	1

### Type of Operation

	Acute Cases	Chronic Cases
Cholecystectomy with drain to site of operation .....	0	8
Cholecystectomy with drainage of cystic duct .....	11	45
Cholecystectomy with T-tube drainage of common duct ....	0	13
Cholecystostomy .....	10	7
Cholecystectomy with T-tube drainage of common duct ....	0	1
Removal of stones from common duct with drainage .....	1	3
Cholecystogastrostomy .....	0	1

### Mortality in 100 Cases—3 Per Cent

Mrs. J. N., age 72. Cholecystostomy for carcinoma of gall bladder. Died 15th postoperative day.

Mr. K. D., age 38. Cholecystostomy for acute hemorrhagic pancreatitis. Died 2nd postoperative day.

Miss I. G., age 55. Cholecystogastrostomy for severe jaundice due to carcinoma of pancreas. Icteric index 140. Died 5th postoperative day.

\*From the Surgical Department of Harper Hospital, Detroit. Read before the Michigan State Medical Society, Grand Rapids, September, 1937.



gall bladder in all cases except the elderly frail patient. In every case I carefully examine the ducts by digital examination and in the majority of cases I open and explore the ducts with a probe or small curette.

I think that drainage of either the cystic or common ducts, depending on the severity of the case, in all operations for removal of the gall bladder is a very important procedure in dealing with this disease. In

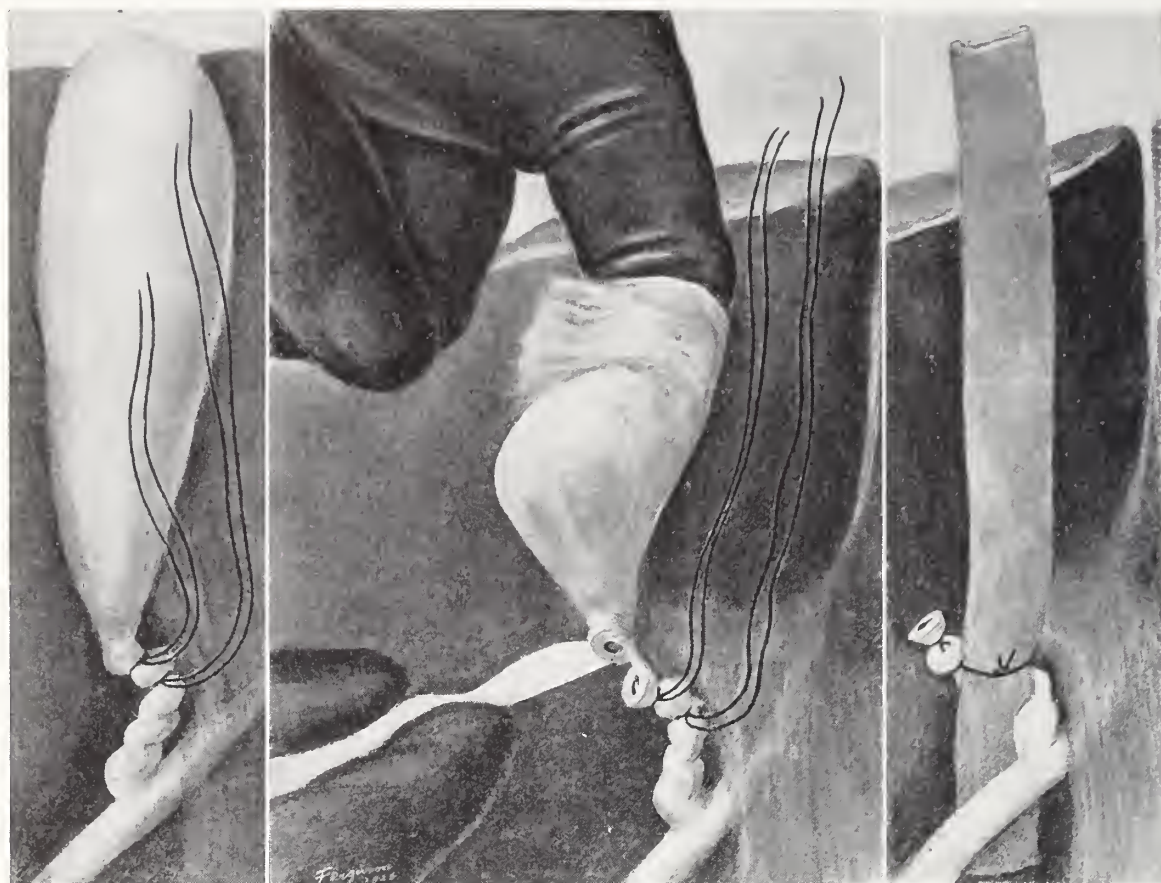
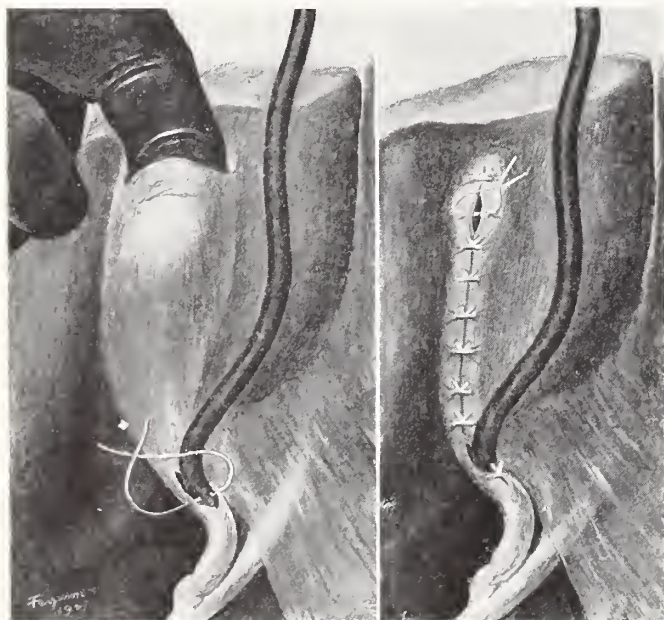


Fig. 1 (left). Technic of cholecystectomy. Two sutures are placed and tied lightly around cystic duct. Fig. 2 (center). Finger is placed within gall bladder and flexed, putting tension on cystic duct, which is divided above sutures.

Fig. 3 (right). Soft rubber drain is placed below stump of duct and tied lightly in place with ends of lower suture, which are tied around duct.



Figs. 4 and 5. The finger is inserted into the gall bladder and flexed, putting the cystic duct on the stretch. A small incision is made in the upper part of the cystic duct, a catheter is inserted into the duct and sutured in place. The gall bladder is then removed. With this technic the good effects of drainage are obtained with cholecystectomy.

the majority of cases of cholecystectomy, a surgeon who removes the gall bladder and does not explore and drain the ducts is not doing a satisfactory or complete operation.

#### The Acute Gall Bladder

In order to reduce the complications of hepatitis, cholangitis, pancreatitis and rupture of the gall bladder with bile peritonitis, all acute gall-bladder cases should be operated on as soon as possible after a short course of preparation. This includes an adequate dose of morphine, or nitroglycerine, emptying the stomach with the Levine tube and counteracting the dehydration and fortifying the liver with large amounts of saline and glucose solution, given subcutaneously and intravenously.

Too many times we have seen the danger signs—chills, high fever, rapid pulse,





Fig. 6. Cholecystectomy in acute cases. When the gall-bladder wall is edematous or gangrenous, the gall bladder is incised down to cystic duct and mucosa peeled out.

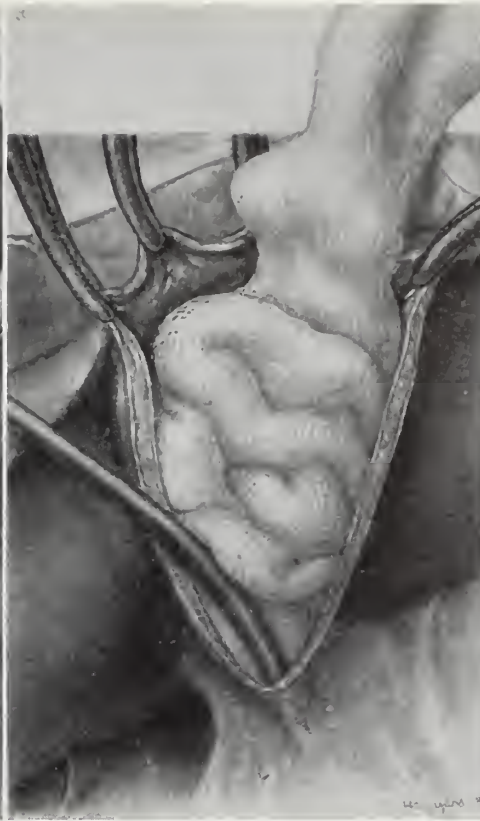


Fig. 7. Gauze soaked in antiseptic solution is packed in the gall bladder. The gall bladder is then bisected to the cystic duct. A tube is inserted into the cystic duct, and the gall bladder is then removed.



Fig. 8. T-tube sutured into common duct.

flushed face and jaundice—come on and become worse while waiting for an acute cholecystitis to subside. The surgical procedure should be conservative, a quick operation and proper drainage. Peeling out the gall-bladder mucosa and drainage of the duct should only be done on patients who are in good condition.

In cases of acute hemorrhagic pancreatitis, in addition to drainage of the gall bladder, drains should be placed down to the pancreas or into the pancreas itself.

Postoperatively, adequate sedation and large amounts of saline and glucose should be given and the Levine tube and oxygen tent used in all cases where the patient is seriously ill.

### The Jaundiced Case

Damage to the liver and pancreas will be greatly reduced by early operation in jaundice cases. Too many cases of so-called painless jaundice are treated expectantly until their condition is desperate. Cases of acute biliary cirrhosis and toxic hepatitis should all have the advantage of early operation and drainage.

Cases of jaundice due to obstruction of

the duct should have the cause removed and drainage instituted as early as possible.

The preparation, operation and after-care of the jaundiced patient presents a special problem of biliary surgery. The liver has so many diverse functions which it can perform in spite of severe damage, and it has such a remarkable regenerative ability, that there is no accurate test of its function which the surgeon can depend upon. Whether the jaundice is due to a disturbance of the liver cells as a complication of the biliary disease, or an obstruction to the flow of bile by calculi, pressure or growths, the surgeon must do all in his power to restore liver function and increase blood coagulation. No one procedure can accomplish this in preparing a jaundiced patient for operation, therefore we combine all the measures we know of which have been shown to be beneficial. We use large amounts of intravenous glucose, calcium by mouth and intravenously, blood transfusions, liver extract, gelatin and concentrates of all the vitamins, especially viosterol. No preoperative period is complete without a thorough saturation of the patient with these measures. The extent of





Fig. 9. Lipiodol injection through T-tube, showing mild dilatation of common duct with the lipiodol passing readily into the bowel. Patient had common duct stones removed six months before, and T-tube was removed soon after this x-ray.



Fig. 10. Lipiodol injection showing moderate dilatation of the ducts. Patient had common duct stones removed two months before and T-tube should be left in.



Fig. 11. Lipiodol injection showing slight dilatation of the ducts. Patient had common duct stones removed two months before and T-tube will soon be ready to be removed.



Fig. 12. Lipiodol injection of ducts showing normal sized ducts and emptying of lipiodol into bowel. T-tube ready to be removed. Patient had cholecystectomy one year before with operation for stricture of the duct one month before this x-ray.



Fig. 13. Lipiodol injection of ducts showing some dilatation of common duct, the other ducts appearing normal. Lipiodol passes into the duodenum normally. T-tube was inserted one year before this x-ray at operation for removal of carcinoma of accessory pancreas. This T-tube was left in for fifteen months after this x-ray was taken.

the operation should depend on a thorough investigation of the cause of the jaundice and what the patient can stand. The main objective is to relieve the jaundice by removing the cause if possible, and, if not possible, by instituting proper drainage.

The ducts, therefore, should be investigated first and the gall bladder saved to be drained externally or internally. If the continuity of the ducts can be easily re-established by removal of calculi, simple drainage of the gall bladder is done. If

the poor condition of the patient does not warrant radical duct surgery, a cholecystogastrostomy or cholecystoduodenostomy should be performed. After the operation careful decompression of the liver should be done, and the bile drainage should be conserved to be given through a Levine tube and mixed half and half with normal saline solution as retention enemas. All of the preoperative measures mentioned above should be continued after the operation until the surgeon is sure that the liver function and blood coagulation are returned to normal.

#### When to Remove the Duct Drainage

In all cases of biliary disease in which duct drainage was used at the time of operation, we have found that the use of the lipiodol x-ray examination is a great aid in guiding us when to remove the drainage tube. This should not be removed until the patient has both clinically recovered and the ducts returned to normal size and function. A small amount of lipiodol is injected into the duct catheter tube or T-tube, whichever is used, and radiographs are taken of the ducts at intervals. Reduction to normal in the size of the ducts and patency of the ampulla of Vater are indications that the duct tubes have served their purpose and may be removed. Samples of this procedure are shown in the illustrations.

#### Late Postoperative Treatment

It is important to keep all gall-bladder cases under observation for six months to a year after the operation. They should be kept on a medium-fat high-acid diet

with the addition of dilute hydrochloric acid if necessary. Their general metabolism should be observed and elimination improved if necessary with the aid of bile salts. I have found Decholin tablets suitable for this use. Some cases complain of attacks of distress in the upper abdomen, sometimes of such a severity as to simulate colic, and I think that this is due to a spasm of the sphincter of Oddi. I have found that the use of the nitrites in these cases, either inhalations of amyl nitrite or nitroglycerine by mouth or dissolved under the tongue, usually gives prompt and dramatic relief.

#### Summary

1. Marked progress in biliary surgery in the last few years has greatly reduced morbidity and mortality.
2. Mild cholecystitis without stones will respond to medical treatment in the majority of cases.
3. All cases of cholecystitis without function, or with stones, whether or not causing colic, are surgical.
4. Early diagnosis, proper preparation, early operation and judicious after-treatment should be practiced in acute cases.
5. Jaundiced cases should have the benefit of every known procedure to counteract liver damage and improve blood coagulation.
6. The use of the lipiodol injection x-ray examination is a great aid in guiding the surgeon when to remove duct drainage.
7. Late postoperative observation and dietary supervision should not be neglected.



## ACUTE HEMATOGENOUS METAPHYSITIS\*

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Acute hematogenous metaphysitis is a clinical entity and to be treated correctly should be diagnosed during the early stage. "If the general resistance of the individual is lowered by ill health and the local resistance is lowered by trauma, the infective process is started, and a small inflammatory area in the cancellous bone near the epiphyseal line results." The cancellous bone near the epiphyseal line referred to above by Starr<sup>11</sup> is the *metaphysis* of the bone and infection or osteomyelitis in this area, he stated, was an inflammation of all the structures of the bone and therefore should be designated peri-osteomyelitis. However, "the earliest clinical phase of acute hematogenous osteomyelitis is in fact acute hematogenous *metaphysitis*," states Hart<sup>4</sup> in an excellent article on this subject. It is this early clinical phase of acute osteomyelitis to which we refer and which should be recognized early if chronic osteomyelitis is to be avoided. The analogy between acute appendicitis and acute metaphysitis as pointed out by Hart and Dillehunt<sup>3</sup> is a very good one and only when we solve this problem as we attack acute appendicitis will such phrases as the following no longer be heard: "Once an osteo always an osteo"; or "The word 'cure' should never be used when speaking of osteomyelitis"; or "I never see osteomyelitis in the acute stage."

Quoting Dillehunt:

"This disorder in the acute state is rarely accepted as a clinical entity by the profession; in practically every instance it remains unrecognized and is therefore neglected in the early state when treatment would do most to prevent unfortunate sequelæ." \* \* \* "Acute osteomyelitis which, though the outcome is seldom fatal, does demand, in nearly every instance, surgical interference or else the victim becomes a subject of prolonged invalidism being in direct ratio to the delay in the recognition of the condition in the acute stage. I believe that this disease causes as great morbidity and crippling as does tuberculosis of the joints or infantile paralysis. It is needless to point out the reasons, chief among which is error in diagnosis." \* \* \* "If a child under thirteen years of age is seized with pain in an extremity, and he shows loss of function, elevation of temperature and leukocytosis, that child has acute osteomyelitis. Any other entity such as acute arthritis, acute articular rheumatism, neuritis, poliomyelitis, is improbable. In such a picture the obligation of the doctor is to determine the point of localized tenderness over the end of a long bone, and, upon recognition of this point of tenderness, to open the cortex and drain."

The patient may or may not have been recently acutely ill, and there is generally a history of trauma which is supposed to

produce a "locus minoris resistentiæ." Some have recently had a "bad cold" or upper respiratory infection, as G. C. in Case



Fig. 1. G. C., aged fourteen years. White blood count 12,400. Temperature 104 degrees. Finger-point tenderness in the distal end of the tibia. Organisms, streptococcus and staphylococcus. Temperature returned to normal on the seventh day. This patient has had no "flare-ups," no sequestra, no metastatic lesions. Roentgenogram shows the postoperative defect in the metaphysis. The intense pain in the end of the tibia was relieved following operation, which was done within thirty hours from the onset of symptoms.

1, or an otitis media as K. B., Case 2, or scarlet fever, measles, tonsillitis, chicken pox, styes or boils. There is a marked rise in temperature usually accompanied by a chill and intense pain near a joint in the metaphysis of a long bone or in the juxta-

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epiphyseal region of other bones. "Point tenderness," says Hart, "is one of the most important clinical observations," while Starr says, "There will be tenderness over a lim-

pathological fractures or deformities, bear evidence to the failure of early treatment.

Recently a case of osteomyelitis that had been treated conservatively was shown at



Fig. 2. K. B., aged twelve years. White blood count 14,900. Organisms, staphylococcus. Tenderness over the distal end of both tibia and fibula. Fibula was drilled and no pus was encountered. Wound was closed and healed normally. The tibia was then drilled and pus obtained. The second film showed an area of activity on the lateral side of the tibia which undoubtedly accounted for the tenderness on the fibular side. The above films show the operative defects in the metaphysis of the tibia. The picture of the ankle shows the scar adherent to the bone after several months of normal activity. This scar has now been excised.



Fig. 3. B. S., aged four years. Acute hematogenous metaphysitis, advanced stage. White blood count 20,800. Culture, hemolytic staphylococcus aureus. Roentgenogram shows postoperative defects in metaphysis, vaseline pack still in place. Picture shows healed scar. Three plaster hip spicas were used on this patient. Normal activity. No metastases.

ited area and most extreme at that point." This sign cannot be emphasized too strongly. It is usually about one and one-half to two inches from the joint in a growing child and can usually be localized with one finger; one might call it finger-point tenderness. Pain on firm local bone pressure was a predominant finding in 63.1 per cent of Robertson's cases in Group 1.<sup>8</sup> Pain on pressure will be over a larger area, however, if an abscess has formed, especially if the periosteum has been ruptured or elevated along the diaphysis. The white blood count is of course elevated. The analogy to appendicitis is again emphasized: pain, fever, finger-point tenderness, elevated white blood count; the white blood count also going up if operation is delayed or if sub-periosteal abscess develops.

The early diagnosis of acute osteomyelitis or acute hematogenous metaphysitis is still rarely made and the many cases of chronic osteomyelitis with either single or multiple lesions, secondary anemia,

a clinic to a group of doctors. The abscess alone had been opened; the patient survived, but how? He now not only had osteomyelitis of the entire diaphysis of the shaft of the long bone primarily involved together with anemia, but also two pathological fractures and metastatic lesions of three other long bones! Although this case was past the stage which we speak of as acute hematogenous metaphysitis yet we believe that if the underlying metaphysis had been opened at the time the abscess was drained convalescence would have been different. The child might have been saved months and years of invalidism and the economic status considerably altered. Case 3, B. S., was a similar case. Her popliteal space abscess was opened and the distal end of the femur drilled and saucerized. Roentgenogram of the operative area and resulting scar is shown six months after onset (Fig. 3).

#### Treatment

Radical resection of the diaphysis is not indicated in these early cases. The lesion



is in the metaphysis in this early clinical stage and not in the *medullary cavity* as presented by Wilson and McKeever<sup>5</sup> in their Group 1. Operation should be done



Fig. 4. L. S., aged eleven years. Temperature 103 degrees. White blood count 14,900. Periosteum ruptured. Epiphyseal cartilage plate partially destroyed. Culture, hemolytic staphylococcus aureus. Roentgenogram shows advanced stage of metaphysitis. Patient had boils at time of onset. Temperature returned to normal on the tenth postoperative day. Patient is very athletic and runs and plays normally. No "flare-ups," no sequestra, and no metastases. The incision was long, due to the advanced stage. Scar has been excised.

early if metastatic lesions are to be prevented. We agree with McKeever that it seems unwise to drain only partially or imperfectly and we emphasize that saucerization or adequate drainage must be made in the *metaphysis* and sometimes almost to the epiphyseal line rather than in the medullary cavity. The epiphyseal cartilage plate must not be damaged surgically, however, or unilateral deformities of the extremity may result.<sup>9</sup> W. S. Bickham,<sup>1</sup> in his *Operative Surgery*, states:

"As soon as the diagnosis of osteomyelitis is made, in order to minimize the destruction of tissue which is otherwise likely to take place, a free incision is made over the site of involvement."  
\* \* \* "The limit of the disease should be the limit of the bone section."

The technic demonstrated in the figures is not the one we advise, however, as the exploratory operation and the osteotomy pictured show exposure of the medullary canal or diaphysis rather than the cancellous bone in the end of the shaft next to the epiphyseal line.

A statement made recently by Cubbins<sup>2</sup> is very timely and is quoted here as given by him in June of this year:

"Many years ago, A. J. Ochsnor operated on some very young children with very thin cortical bones and observed the pus exude directly through the cortex and the children recovered after an incision of the periosteum. You will readily see that to the light thinking individual this meant that the periosteum could be opened in older individuals with a dense cortex. Many tragedies resulted from this erroneous deduction.

"What I really wanted to say was that when in doubt the only safe plan to pursue is to make an early incision into the bone. The type of opening is of little consequence and should cause no argument; what is of vital importance is that the bone be opened correctly and early and the pus allowed to extrude."

Dillehunt again states:

"In the definite treatment, the object to be attained is radical excision and obliteration of the defect surgically, for which no substitute, such as antiseptic, injections, or maggots will ever do."

McKeever cites the rate of 25 per cent in Group 1, or the group who had early adequate drainage of the *medullary canal* within seven days of the onset of illness; our experience has been quite the opposite of this. A few cases have shown continued activity by x-ray and by temperature chart. These have been curetted usually further toward the epiphyseal line, and in this advancing stage also toward the medullary canal when subsequent dressings were done. In young children, especially, the process extends rapidly along the diaphysis. No patient treated in the early clinical phases of acute hematogenous metaphysitis has ever developed more than an occasional small sequestrum which in every case was removed with hemostat at subsequent dressings and none has developed other metastatic bone lesions in a period of four years.

The Orr<sup>7</sup> treatment has been most satisfactory in all of our cases. One must first rule out as a cause for the fever such conditions as otitis media, tonsillitis, upper respiratory infection, or pneumonia, pyelitis, etc. If the child is exremely ill, septicemia must be ruled out (Mitchell<sup>6</sup>). Blood cultures should be taken, fluids given subcutaneously, whole blood transfusions and perhaps sulphanilimide, given. Operation on the bone may have to be delayed until the patient's condition will warrant it. If none of the above conditions are present and the patient has the clinical picture of acute hematogenous metaphysitis above described, roentgenograms are made, which of course should be negative. A tourniquet

is applied to the lower extremities or a sphygmomanometer or Baumanometer to the arm with the pressure held at about 240 as advised by Dr. Sumner Koch for operations on the hand. The foot or hand should first be elevated for a few minutes prior to tightening these tourniquets so that a bloodless field will be secured. If these are not applied correctly, the venous blood will obstruct the picture and small pockets of pus in the cancellous bone will be missed.

The periosteum, which will be found edematous and thickened, should be incised but not unnecessarily elevated or removed from the bone, as it is needed for reparative purposes. A drill hole is made through the cortex into the metaphysis near the epiphyseal line and a culture is taken. If the tourniquet is working satisfactorily and if the diagnosis is correct, usually pus which is under pressure will be seen beginning to exude through this drill hole. If, however, it is not under pressure and if you have not entered the proper area further drill holes may be necessary. If a mistake in diagnosis is made and no pus and negative smears are obtained, no harm has been done and the wound may be closed. If pus is secured the metaphysis should at once be saucerized as advised by Starr, Cubbins, Dillehunt, Hart and others.

If the incision has been made through a muscular area we have found it advantageous to suture the fascia to the deeper surface of the muscle or to the periosteum. This helps keep the wound open and permits it to be packed more easily with vaseline gauze at subsequent dressings. The cancellous bone is saucerized toward the epiphyseal line until all areas from which pus escapes have been curetted out. This can not be done so completely in a bloody field. The wound is then irrigated or sponged out, care being taken not to injure the epiphyseal plate (Speed<sup>10</sup>) and the wound is packed with vaseline gauze. A plaster cast is applied to include the joint above and below the area involved to give complete rest. If in the femur a hip spica or if in the humerus a plaster shoulder spica will be necessary. When the first and second dressings are done, in about four and six weeks, roentgenograms are made with the cast removed. This may be necessary as early as two weeks if the patient should

still be running a high fever, or showing signs of continued activity. The wound is cleansed and the bone is sounded with a curette to determine if there are any areas



Fig. 5. E. D., aged ten years. Acute hematogenous metaphysitis of humerus. Onset followed "boil in nose." White blood count 17,800; organism, staphylococcus. Temperature returned to normal on the eighth day. Roentgenogram shows operative defect in metaphysis of humerus. Two plaster shoulder casts were used. Treatment by Orr method. No sequestra, no metastases. Scar has not yet been excised.

of softening or pockets; if so these are gently curetted out and if any small sequestra are present these are pulled out. Excess granulation tissue is pinched off with a hemostat or cauterized with silver nitrate. The wound is again packed with vaseline gauze and the cast applied as before. The vaseline gauze should be packed loosely in the wound only and not on the surrounding skin. This helps prevent maceration of the skin. Should maceration occur, however, zinc oxide ointment may be applied on the skin surface. This treatment is continued at monthly intervals, keeping the part at rest and without weight bearing until the wound has closed. The patient should be instructed to lie on his face or side several hours per day to insure dependent drainage. Sometimes the vaseline gauze will be found completely extruded and the incision closed at the time of the second or third dressing.

In the interim between dressings if the patient's temperature is normal he may be up with crutches, or a sling, and should secure as much sunshine, and fresh air, as possible. The hemoglobin must be watched and iron prescribed as needed. Following the healing of the wound and after the



patient has been carrying on normally for several months the scar tissue should be excised. This is to lessen the possibility of trauma to the involved area and to help prevent a "flare-up" of the condition. Most frequently skin grafts will not be necessary as the soft tissue can be "under-cut" and pulled together giving a normal cushion over the bone. Parallel incisions in normal tissue may be necessary to permit the skin edges to come together.

### Summary

Much of the deformity and disability incident to osteomyelitis is preventable. Osteomyelitis should be diagnosed and treated surgically during the first twenty-four to forty-eight hours, while it is still in the clinical stage of acute hematogenous metaphysitis.

Tourniquets should be used when possible to insure adequate saucerization of the cancellous bone and help prevent surgical damage to the epiphyseal cartilage plate. Lying on the face or side should be encouraged to insure better drainage. The fascia or

skin edge may be sutured to the deepest portion of muscle or periosteum to help keep the wound from closing too rapidly and make subsequent dressings easier.

When the wound has been healed for several months and normal activity has not caused a "flare-up" the adherent scar tissue should be excised and the previously infected area covered with normal soft tissue.

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## TUBERCULOSIS AND PREGNANCY\*

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A review of the literature on tuberculosis and pregnancy will show that until recently there were two principal and opposing attitudes on treatment. Opinion in this country and Germany was prevailingly radical, the tendency being to empty the uterus whenever tuberculosis was discovered before the middle of pregnancy. This attitude was based chiefly on the now questionable belief that pregnancy usually causes a serious exacerbation of tuberculosis. A secondary reason was the natural desire to eliminate all complications, including pregnancy, in order to concentrate on the treatment of the pulmonary condition. Often, no doubt, the patient's desires in the matter and her economic situation also had considerable influence. In most communities the dearth of sanatorium accommodations was, and still is, a deciding factor at times. One hears such secondary reasons for the radical attitude condemned as unscientific, and undoubtedly their importance has been unduly exaggerated on many occasions. However, it should be protested that the practice of medicine is not a pure science, and justifiable expediency in the interests of the

patient may sometimes lend such considerations a more than incidental importance.

Contrary to the radical attitude, with its emphasis on the welfare of the mother, there is a considerable opinion opposed to therapeutic abortion under any circumstances. Such a position is no longer actuated entirely by prejudice in favor of the child, as was formerly stated, but now has some scientific support in certain comparative studies of cases with and without therapeutic abortion. Some of these apparently show little or no advantage in interruption of pregnancy for tuberculosis. On the

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other hand, a few authors, while expressing opposition to therapeutic abortion, give statistics which on close examination actually indicate that pregnancy allowed to go to term may be harmful. Moreover, the small numbers in the series presented by the extreme conservatives and the frequent disregard of important data leave one far from convinced that the matter is thus settled from a medical standpoint. However, we are indebted to this group for their demonstration of how safely many tuberculous women can be carried through pregnancy with efficient treatment.

As is so often the case, the truth probably lies somewhere between the extremes. Certainly, many tuberculous women show no exacerbation with pregnancy—a few even seem to be somewhat benefited. On the other hand, there are those in whom pregnancy is a tragedy leading to irreparable progression of the disease. Because of these recognized facts, the recent trend is away from a fixed attitude in either direction and toward individualized treatment based on an interpretation of the findings in each case. It is true, unfortunately, that our knowledge is not yet sufficient to permit a satisfactory evaluation of all situations. However, in the majority of cases an approach, at least, towards rational management is now possible.

The following cases illustrate some of the common problems encountered in practice:

*Case 1.*—The first case is that of a primigravida, twenty-five years old, who had been married one year. Three years previous to her marriage she had received adequate sanatorium treatment for active though minimal pulmonary tuberculosis and had been discharged with the disease arrested. On a regular visit to her physician there were noted râles which had not been present before. The last menstrual period had occurred six weeks previously, and pelvic examination revealed the signs of probable pregnancy. In spite of strict bed-rest treatment, the chest signs became more pronounced and finally were associated with a daily low grade temperature elevation. After a month and because of progression in spite of treatment, it was decided to empty the uterus, the duration of the pregnancy being about ten weeks. Therapeutic abortion was induced by slight dilatation of the cervix and introduction of a catheter, no anesthetic being required. The ovum was expelled spontaneously the next day with only slight blood loss. Recovery was rapid and so satisfactory that six months later the patient was permitted by her physician to undertake a short foreign tour.

*Case 2.*—The second case was that of a married woman, twenty-three years old, pregnant for the

second time. The first pregnancy had occurred six years before and was uneventful for the mother, but the baby had spina bifida and died soon after delivery. Three years ago she was found to have advanced pulmonary tuberculosis with involvement of the larynx. She received treatment under the care of Dr. A. B. Wickham in a private sanatorium and later at home. After two years the tuberculosis was considered arrested, and the patient remained in fairly good health for the year preceding the second pregnancy.

The patient was seen for obstetrical care when she was about eight weeks pregnant. Dr. Wickham believed the prognosis to be dubious because of the extent and type of tuberculous lesion and because of rather marked nausea and vomiting associated with the pregnancy. However, with excellent coöperation in regard to bed-rest and with partial control of the nausea the condition remained satisfactory. At the end of the third month there had been a weight loss of less than five pounds, the temperature had been up to 99° F. only three times, and there were no signs of renewed activity in the lungs. The remainder of the pregnancy was normal, the total weight gain being twenty-five pounds. Labor was spontaneous, lasting approximately fourteen hours. Sodium amytal and scopolamine analgesia was given during the first stage and nitrous oxide-oxygen in the short second stage. Blood loss was slight. The child was a normal male weighing six and three-quarters pounds.

The puerperium was uneventful. The child was not put to breast. Following discharge from the hospital the patient was kept under frequent observation on a schedule of restricted activity. Her temperature remained normal, x-ray showed no progression in the lungs, and five months after delivery she weighed nine pounds more than at the first visit.

It is obvious that these two patients had many points in common, yet in one the uterus was emptied while the other was allowed to go to term. The explanation for this difference in treatment is not found in the extent of the pulmonary lesions. Actually, the patient who was not aborted had a definitely more extensive degree of tuberculosis. The decision depended on the influence of the pregnancy on the tuberculosis. In one there was definite exacerbation but in the other no evident ill effect.

A third case to be presented did not offer such clear-cut reason for the treatment instituted. Indeed, we frankly admit that from a strictly scientific standpoint the indication was questionable, but nevertheless after considering all sides of the problem we felt justified in doing therapeutic abortion.

*Case 3.*—Mrs. T. C. was a clinic patient, twenty-two years old, who was admitted to the hospital in May, 1936, in the eighth week of her second pregnancy. Five years before, at the age of seventeen, she was found to have a childhood type of tuberculosis and was kept in bed for six weeks. Following this her health was only fair, but she was married eighteen months later. Two weeks after her marriage there occurred what she called

a "nervous breakdown," requiring treatment in an institution for four months. In April, 1934, when twenty years old, she became pregnant, and between the third and fourth months there was definite progression of the pulmonary condition. However, she went through pregnancy in fair health and was delivered at term in January, 1935. Her condition now became progressively worse, and in May, 1935 (five months after delivery), she entered a sanatorium where she was treated for six months. Apparently the tuberculosis was arrested as she felt well and gained a little weight in spite of her housework, the care of her baby, and the unemployment of her husband due to partial disability from a foot injury, the family being on relief.

The patient was admitted to the hospital on May 15, 1936, approximately six months after discharge from the sanatorium. The date of the last menstrual period was March 18. She stated that she had recently lost eight to ten pounds in weight. Roentgen-ray examination showed healed tubercles in the upper lobe of the right lung and tracheobronchial adenopathy but no active parenchymal process. The sputum was negative for tubercle bacilli. However, there was a daily temperature elevation between 98.8° and 101° F. There was also a moderate secondary anemia.

On May 22, 1936, the cervix was dilated and the uterus emptied under spinal anesthesia. Following operation the slight daily fever continued, but otherwise there were no complications. The patient was discharged from the hospital to receive medical care and contraceptive advice through the outpatient department.

In deciding on therapeutic abortion in this case, consideration was given to the well known fact that pregnancy so soon after active tuberculosis often leads to dangerous reactivation. The loss of weight and the fever made this possibility seem imminent. Although it was recognized that the hazards might be materially reduced by efficient treatment, it was even more certain that because of the economic and family situations the patient would be unable to receive proper care for her tuberculosis. Under better circumstances, the procedure would most likely have been more conservative—at least to the extent of delaying decision until the third month with the hope that a trial of treatment would afford an indication of the probable effect of the pregnancy.

### General Discussion

The problem of pregnancy with tuberculosis, as is true in practically all obstetrical situations, involves the welfare of two individuals—the child and the mother. Consideration of the prognosis for the former may be disposed of briefly. The much discussed danger of intrauterine transmission of the disease is probably too slight to arouse more than scientific interest. On the

other hand, it is true that babies of tuberculous mothers may be inferior in weight, development, and general vitality and resistance as compared to those born under normal conditions. However, they generally do reasonably well if the one precaution of immediate and strict isolation from the mother is observed. This means of course that nursing is contraindicated. It seems proved without doubt that neglect of complete separation from the mother leads to frequent infection and a high infant mortality rate. Indeed, this precaution is so essential that one might even go so far as to say that the obvious impossibility of having such measures instituted after delivery should justifiably have some influence on the decision regarding therapeutic abortion early in pregnancy. Those who may question this statement are referred to the literature which gives an infection incidence of over 50 per cent for infants in contact with tuberculous mothers and a mortality rate ranging between 28 and 78 per cent during the first year.

For the mother the complication of pregnancy with tuberculosis is always a potential threat to her welfare and may even lead to her early death due to exacerbation of a tuberculous condition which otherwise would have been controllable. Recognizing this danger for some but also with the knowledge that the majority of tuberculous women can be carried through pregnancy without harm, more and more specialists in tuberculosis and in obstetrics are attempting to evaluate the situation in each case as a guide to treatment in that individual. Jameson states that, "Both pregnancy and tuberculosis are subject to so many variations in themselves that their reactions one with the other are bound to have diverse effects upon different patients and to be associated with a complex prognosis that cannot be embodied in a dogmatic formula." Unfortunately, our present knowledge in regard to these variations is inadequate for an entirely satisfactory approach to the problem. However, by making use of the information which we have, it is possible to arrive at some conclusion regarding the prognosis and the advisable procedure in a given case.

In reviewing the available data for rational management of these cases, it may be assumed, as indicated above, that pregnancy,



while not adversely affecting all tuberculous women, is always to be regarded as a potential danger. This is the overwhelming consensus of opinion though it is denied by a few. The latter believe that the usual tendency of tuberculosis toward progression has been generally ignored and that exacerbations commonly ascribed to pregnancy are coincidental only and in keeping with the natural history of the disease. Granting that there are some grounds for such reasoning and that it is useful in discouraging exaggeration in the other direction, the fact remains that there is good evidence to the contrary. Without going extensively into the subject, it can be said that the high percentage (averaging 42 per cent for a number of reports) of married women with tuberculosis who first became aware of the disease during or shortly after pregnancy is more than suggestive. If further proof is necessary, we need only point out that reactivation as illustrated by our first case is far too common to be explained by mere coincidence.

The missing data which would be most valuable to us in the management of tuberculosis complicated by pregnancy is exact information as to how pregnancy affects the pulmonary condition. To know the cause would be to open the way for discovery of the remedy. Efforts so far have led only to more or less possible explanations such as: 1. The nausea and vomiting of early pregnancy; 2. Bleeding and physical exertion of labor; 3. Lactation; 4. The tendency toward demineralization; 5. Changes in the level of the diaphragm; 6. Increased metabolic requirements of pregnancy; 7. Increased blood cholesterol, or 8. Decreased lipolytic ferments; 9. Endocrine changes; 10. Reduction in tuberculin reactivity, and 11. Alterations in the permeability of the capillaries. Probably when all is known, no single factor will be found entirely responsible. The first four almost certainly have a deleterious effect but fortunately can and should be eliminated or controlled.

The influence of parity is of some interest since it is generally agreed that women in the first pregnancy do better than multiparæ. Perhaps the additional household duties of those who have children explain the difference. Certainly, repeated and frequent child-bearing lowers the resistance to

infection of any type and should be taken into account when tuberculosis is present.

It is well established that, other things being equal, the woman already aware of her tuberculosis when she becomes pregnant does better than one in whom active tuberculosis is discovered after pregnancy is under way. The explanation for this difference is no doubt found in the better information of the former. She realizes her danger and seeks medical care early, but also of importance is the fact that she has been instructed how to avoid conditions unfavorable to her tuberculosis. Obviously, the other should enjoy the same advantages if the first prenatal examination were done early and thoroughly, with the chief reliance placed on x-ray for the diagnosis of tuberculosis.

Of great importance in arriving at a prognosis for the tuberculous pregnant woman is the consideration of the type of involvement with which she is affected. It is recognized that those with early or minimal lesions fare better in general than those with extensive tuberculosis. With the latter, the tendency is to be more radical,—provided that the pulmonary condition is not so advanced as to preclude the possibility of recovery. In hopeless situations therapeutic abortion is usually contraindicated as useless, though in some cases it may be undertaken where there is a probability of prolonging life. In certain special types of tuberculosis the old idea favoring interruption of a co-existing pregnancy has been considerably modified. The fatal outcome in practically all cases of miliary tuberculosis and tuberculous meningitis could hardly be affected favorably by abortion. Laryngeal tuberculosis is no longer considered an absolute indication *per se* but rather as evidence of an advanced pulmonary condition. Hemoptysis during pregnancy is now being treated in some places by collapse therapy, but it is still too early to say with what result.

Of equal, or perhaps more, importance than the extent of the tuberculosis is its activity. The rule is that acute forms and those with exudative infiltrations are far more dangerous with pregnancy than the chronic, the fibrous, and the arrested types. Our second case shows that arrested lesions even though extensive may be little affected by pregnancy. The belief is that three to



five years of quiescence makes pregnancy fairly safe, though even here patients should be watched closely since reactivation may occur in a few as illustrated by our first case. Definitely active involvement, especially if the lesion is open or the patient toxic, often makes therapeutic abortion imperative.

When the two factors regarding the tuberculosis itself (*i.e.*, extent and activity) are considered together, we may find for example that the lesion is small with little or no activity. The outlook, then, would be good. At the other extreme would be an extensive and highly active lesion, the prognosis being more than dubious with a pregnancy. Between the extremes is a large group of patients about whom it is difficult or impossible to come to an immediate decision even after taking into account the type of lesion and the other factors such as parity, nausea and vomiting, financial resources, availability of care, etc. When such patients are seen sufficiently early in pregnancy, they should be put to bed under treatment, preferably by a phthisiologist, for at least a month or until the twelfth or fourteenth week. By the end of this time the temperature curve, weight, x-ray studies, etc., will give a definite prognosis in the majority. In some there will be improvement or at least no progression, and in these the pregnancy may be allowed to go to term with reasonable assurance of little or no harmful effect. In those with definite exacerbation in spite of bed treatment there is a clear indication for therapeutic abortion. For others the phthisiologist will be unable to give a definite opinion, and here there is a real problem in management which at times can be solved none too satisfactorily even after a most conscientious consideration of the various factors involved. Fortunately, this third group is comparatively small, and with accumulating knowledge it will become smaller.

Before definitely deciding on interruption of pregnancy in a given case, there are certain things to be considered. In the first place, we would do well to remember that therapeutic abortion is an operative procedure associated with a definite mortality, though it is true that the danger before fourteen weeks is not excessive. After four or four and a half months it is universally conceded that intervention is gen-

erally contraindicated, regardless of the pulmonary condition, since the procedure for late emptying of the uterus not only carries a greater operative risk but also is quite as harmful to the tuberculosis as permitting the pregnancy to go on to term and delivery. It is probably unnecessary to mention the fact that emptying the uterus has no curative value in itself. It simply eliminates the additional dangers of pregnancy, leaving the patient as before in need of treatment for her tuberculosis. In the technic of therapeutic abortion the essential thing is to empty the uterus in the simplest and easiest manner possible. Early in pregnancy this can frequently be accomplished without anesthetic by the introduction of a catheter into the uterus or by packing the cervix with a gauze strip. If there is no result in twelve or eighteen hours, the patient may be given one of the gas anesthetics or spinal anesthesia for instrumental dilatation of the cervix and curettage with a dull curette. The questions of sterilization and the advisability of repeated therapeutic abortions should be largely avoided by instruction in contraception.

While we have been learning how the majority of pregnant tuberculous women may be carried safely to term, the management of delivery in these cases has received more attention. Cesarean section usually presents no advantages here over vaginal delivery and is therefore rarely indicated. In labor every effort is made to protect the tuberculous patient from pain, physical effort, and loss of blood. Analgesia by some good method is always indicated in the first stage. Exertion in the second stage is reduced to a minimum by early resort to forceps. Nitrous oxide-oxygen or ethylene-oxygen anesthesia does little or no harm though spinal anesthesia is preferred by some. Blood loss in the third stage is limited by prompt expression of the placenta as soon as separation has occurred and by the free use of pituitary extract and ergot. The puerperium is managed as usual except that nursing is not permitted because of reasons given before.

Finally, and without any intention of invading the field of the phthisiologist, a word about collapse therapy and pregnancy should be of interest here. Judging by the literature, artificial pneumothorax is being used more and more in tuberculous women

during pregnancy. In general it seems to have been well tolerated if already established before pregnancy or started in the early months. This procedure, however, though often helpful, can be used only in suitable cases and has not yet shown sufficiently striking results to greatly modify the indications for and against therapeutic abortion. Artificial pneumothorax is of course frequently instituted immediately following delivery on the usual indications. Apparently, phrenicectomy has seldom been done during pregnancy, but there seems to be no reason against it. Pregnancy after thoracoplasty has been reported in a few cases. Theoretically there might be respiratory embarrassment in labor though this was not noted in the cases reported. Probably the chief danger from pregnancy lies in the possibility of reactivation of the tuberculosis which of course was an advanced lesion or the operation would not have been done. In at least one case thoracoplasty was done during pregnancy, but until there is further evidence to the con-

trary the approved course usually would be to empty the uterus first.

### Summary

The illustrative cases given and a review of the literature demonstrate that there can be no dogmatic formula for the management of tuberculous women who are pregnant. Instead, each patient should be individualized and allowed to go through pregnancy or aborted according to the prognosis in her case. Some of the important factors and findings upon which a rational prognosis and treatment may be based are outlined. The limitations and technic of therapeutic abortion are discussed. It is essential that tuberculous women in labor be guarded against pain, physical exertion, and hemorrhage. Collapse therapy has recently found a useful though limited place in the treatment of pregnant tuberculous women, but so far has shown little promise of greatly modifying the present indications for therapeutic abortion. Babies should be separated from tuberculous mothers.  
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## LUTEIN CYSTS ASSOCIATED WITH CHORIOMA\*

### Case Reports

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The term chorioma includes all tumors or tumor-like structures composed of the cells of the chorionic epithelium. These cells arise from the fetal ectoderm and are responsible for both benign lesions and very malignant ones. Included under chorioma are such lesions as hydatidiform mole, typical chorio-epithelioma, chorio-adenoma destruens, or destructive placental mole, chorio-carcinoma, atypical chorio-epithelioma, syncytioma, and syncytial endometritis.<sup>2</sup> Hydatid moles are of frequent occurrence. The etiology of these strange lesions has never been adequately explained.<sup>6</sup> It is said that this type of lesion occurs in one out of every 1,500 to 2,000 cases of normal pregnancy, usually in the third or fourth months.

Between the fully developed hydatid mole and the normal ovum a number of transition stages exist. Healthy children have been born, a small part of whose placenta has undergone hydatidiform changes. Twins, the one normal, the other represented by a hydatid, have been observed repeatedly. These changes demonstrate that no fundamental difference exists be-

tween hydatid and the normal products of conception.

Moreover, the hydatid mole is a degenerative lesion of the placenta, it produces certain changes usually associated with pregnancy, and is more common in women who have borne other children, and often recurs. The most striking of these are the decidua formation in the uterus and enlargement of the breasts. Even if untreated, the uterus which harbors a mole may expel its contents in the third to the fifth month, like a uterus at term. Complications ordinarily seen in pregnancy—

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hyperemesis, toxemia and eclampsia—may occur and are of greater frequency in molar pregnancy.

Direct transitions from the hydatid mole to malignant chorio-epithelioma are numerous. Within the past forty years, approximately one thousand cases have been reported. It is stated that 16 per cent of hydatid moles become chorio-epitheliomas and 50 per cent of the latter are preceded by hydatid moles.

The ovarian changes in chorioma constitute an interesting feature and it is on the course and treatment of this condition that our interest centers.

The hormones of the anterior pituitary gland must be considered as etiological factors in certain tumors of the ovary because of the frequency with which theca lutein, corpus luteum, or granulosa lutein cysts are seen in the ovary in cases of hydatidiform mole or chorio-epithelioma. Such cysts probably owe their development to over-stimulation from the luteinizing hormone found in such quantities in the urine during the presence of pregnancy, mole, or chorio-epithelioma. The fetal cells responsible for the hormone perhaps stimulate the development of this tumor directly, or the hormone may act upon the pituitary, which in turn acts upon the ovary.

Marchand,<sup>4</sup> in 1898, first called attention to the association of hydatidiform mole and chorio-epithelioma with ovarian changes, these ovarian disturbances being known as lutein cysts. At first it was thought that lutein cysts developed only with the two conditions mentioned, but Novak has observed at least one case in absence of any pregnancy. Robert T. Frank<sup>5</sup> feels that 50 per cent of the cases in chorioma develop bilateral ovarian cysts. Cottalorda's<sup>1</sup> study showed lutein cysts to be present in 59 per cent of cases of hydatidiform mole and 9.4 per cent of chorio-epithelioma. However, since most of the cases of lutein cysts associated with hydatidiform mole are not seen in the pathological laboratory, an accurate estimation of the percentage would seem rather difficult. In etiology some believe that hydatidiform mole is the result of the ovarian disease, while a greater number of observers consider the characteristic ovarian change secondary to the hydatidiform disease.

The Aschheim-Zondek test for pregnancy and the results of their experiments has thrown considerable light on this subject. This reaction is probably ten to fifteen times stronger in the presence of mole or chorio-epithelioma than it is in normal pregnancy. Aschheim-Zondek<sup>10</sup> came to the conclusion that the hormones in the urine of pregnant women causing the changes in the ovaries of sexually undeveloped rats, on which they base their biological diagnosis of pregnancy, have their origin in the anterior lobe of the hypophysis.

Gilardino and Mazzone made a systematic study of the effect of injection of the urine of pregnant women into guinea pigs. They injected urine in varying doses and compared the changes brought about in the ovaries with the picture of hydatidiform mole. The animals were killed thirty-six hours after the last injection. In all of them, the ovaries had increased to five or six times their normal size and showed follicular cysts of varying sizes. Some of them contained blood and the histological changes in many respects resembled those of the hydatidiform mole.

On the basis of their findings, they state that the pregnancy hormone of even normal women is capable of causing small cysts, similar to those seen in hydatidiform mole, and that hydatidiform mole is evidently caused by an exaggerated production of this hormone.

The ovaries of women with hydatidiform mole or chorio-epithelioma react to the abnormal amount of prolactin in the blood by developing into a polycystic mass, which frequently assumes voluminous proportions. There is no polycystic reaction of the ovaries after the mole or chorio-epithelioma has begun to degenerate. When the mole is cured by intervention, the cysts regress spontaneously and progressively, and the amount of prolactin in the body fluids diminishes. If the mole degenerates into a chorio-epithelioma, the cystic lesions progress, finally drawing the attention of the clinician.

Novak<sup>7</sup> recently reported two cases of hydatidiform mole and two of chorio-epithelioma, in all of which the ovaries are available for study, and in one case the pituitary gland was also available. He compared the ovarian changes following

mole and chorio-epithelioma with those following anterior pituitary implantations and injections, and notes they are very similar. Histological studies of the pituitary in one of his cases, and also the biological studies which a number of authors describe, leave little doubt that the anterior pituitary is the immediate cause of the lutein hyper-reaction seen in the ovaries of such cases. The trophoblastic increase in hydatidiform mole and chorio-epithelioma are responsible for the pituitary reaction, and the latter in turn calling forth the abnormal ovarian response.

### Pathology

The cysts are usually bilateral. The ovaries may vary from normal size to the size of an adult's head. They are multilobulated, consisting of numerous small cysts, remotely resembling small, polycystic kidneys. The individual cysts are thin walled and filled with clear, cloudy or bloody fluid. Microscopically, there is sometimes difficulty in finding distinct cell elements in the cyst wall. Early cysts show great increase in the theca lutein cells, wide-spread and rapid development of many follicles to the ripe stage, equally rapid cystic atresia and diffuse edema of the stroma. Many cysts lose their lining of granulosa cells.

These changes when analyzed are seen to consist of an over-hasty growth and an exaggeration of cystic atresia of follicles, together with intensification of the lutein development.

### Treatment

Choriomas are very interesting tumors, the diagnoses are difficult and mistakes of serious import may easily be made.

Evacuation of the intra-uterine lesion, with careful observation of the patient afterwards, is the treatment of choice. After a mole has been evacuated, the patient should be carefully observed and an Aschheim-Zondek test repeated in fifteen days, since Bourg has rather definitely proved that the Aschheim-Zondek test is usually negative in that period of time after removal of the mole. If the pregnancy test is positive further investigation should be done.

If the pathologic tissue has been completely removed from the uterus, the cysts will regress. If not, the cysts will become more prominent and cysts not pre-

viously observed may become palpable. It is generally believed that a chorio-epithelioma undergoing degeneration will also cause regression of the cysts. Metastatic processes control the cyst activity precisely as the primary intra-uterine pathology does, and one should be on the lookout for metastasis.

Attempts to classify four types of chorio-epithelioma, and from this classification to determine prognosis, are unreliable, according to R. T. Frank.<sup>4</sup> He followed eighty-five cases, classified them, but found that the treatment that was most satisfactory was complete operation, and practically 100 per cent of those unoperated died. If after a hydatidiform mole is removed, and the cysts persist with the pregnancy test positive, the uterus should be curetted for diagnostic purposes. If chorio-epithelioma is found, a panhysterectomy should be done. Some observers believe that in young women the lutein cysts should not be removed. Since chorio-epithelioma is so very malignant, however, the best treatment is panhysterectomy.

Vineberg<sup>5</sup> warns against repeated curettage, owing to the fact that metastases usually occur and that these take place by way of the blood stream. Even in the case of extensive local metastases, Vineberg claims that the outcome following hysterectomy may be good and that early diagnosis, without repeated curettage, gives a fairly good prognosis.

Wide excision of the parametria is not indicated. Hitschmann advocated extirpation of the deep pelvic veins, but Vineberg claims that these vessels and the lymphatic glands are seldom involved.

The value of radiation in the treatment of chorio-epithelioma has been demonstrated by Zintz, eight of eleven cases having remained well over a period of two to thirteen years.

Eymer<sup>3</sup> advocates radiotherapy alone or following operation, although the number of cures by radiation is small.

### Case Reports

*Case 1.*—Mrs. M. F., aged twenty-five, was admitted to the hospital April 16, 1932, complaining of a dark-brown discharge, swelling of the ankles and an amenorrhea dating from January 1. The patient was examined April 1, and was considered to have a normal pregnancy of three months duration, but within two weeks the abdomen had increased to the size of a six months' pregnancy.



On April 17, the uterus was emptied of a large hydatidiform mole. Considerable bleeding occurred and the patient was transfused immediately after the operation. On the third postoperative day a mass was noted in the left lower quadrant. This increased rapidly in size and on the 5th day a mass

At the present time the patient is symptom-free.

Case 3.—Mrs. H. C., aged forty-three, was admitted to the hospital August 3, 1933, complaining of pain, and increase in size, of the lower abdomen.

Four months previous to admission the patient began having some pain over the abdomen. She had



Fig. 1 (left). Photograph of Case 1 when the lutein cysts were the largest. The dark areas outline the cysts.

Fig. 2 (right). Specimen removed from Case 1 three and one-half months after evacuation of the mole. It shows the regression in the size of the ovaries and the infiltrating chorio-adenoma destruens of the wall of the uterus.

was noted on the right side. The tumors increased steadily in size for two weeks. They extended well above the umbilicus. A diagnosis of lutein cysts was made. The Aschheim-Zondek test was positive. The patient was discharged on the fourteenth day postoperative.

Two months after discharge from the hospital the tumors had entirely disappeared and the patient menstruated normally for a week. A month later she developed a persistent bloody vaginal discharge and a second Aschheim-Zondek test was strongly positive.

The patient was re-admitted to the hospital. During the course of a curettement there was so much and persistent hemorrhage that a panhysterectomy was performed. The pathological report on this specimen was (1) Chorio-adenoma destruens (destructive placental mole); (2) multiple follicular and lutein cysts of ovaries.

This patient is very well at the present time and has not had any menopausal symptoms.

Case 2.—Mrs. DeA., aged twenty-five, was admitted to the hospital March 3, 1933, complaining of nausea, vomiting, vaginal bleeding and loss of weight. Her last normal menstruation was November 25, 1932—six weeks after the last menstruation vaginal spotting began, which increased to considerable bleeding. She was confined to bed for several weeks. During this time there was a weight loss of 30 pounds. Examination on admission showed a young woman in poor condition with a tumor mass fully the size of a 7 months' pregnancy. After intravenous infusions and a blood transfusion a vaginal hysterectomy was done and 6 quarts of hydatidiform mole was removed.

She made an uneventful recovery and was discharged from the hospital on the 12th postoperative day.

Six days after her discharge from the hospital she began bleeding profusely again. The Aschheim-Zondek test was positive.

April 1, a diagnostic curettage was done. The uterus was large and very soft. A great deal of the uterus had been destroyed and the placental forceps perforated the wall. An immediate panhysterectomy was performed.

Pathological diagnoses were: (1) Chorio-adenoma destruens; (2) follicular and lutein cysts of ovaries.

noticed some vaginal bleeding throughout the previous month. The menstrual cycle had occurred every two months.

A pre-operative diagnosis of multiple fibroids was made and a laparotomy was done. The uterus was found to be uniformly enlarged, soft and with a bluish color as of a pregnant state. No fetal structures could be felt through the uterine wall. Both ovaries were the size of a grapefruit. Because of the age of the patient, a supravaginal hysterectomy and a bilateral salpingo-oophorectomy was done. The patient made an uneventful recovery.

Pathological diagnoses were: (1) Hydatidiform mole; (2) bilateral lutein cysts.

The Friedman test three months later was negative.

Case 4.—Mrs. H. S., aged thirty-two, para II, entered the hospital October 8, 1936, complaining of vaginal bleeding.

Her last normal menstruation was June 14. During the latter part of August, she began spotting—this had persisted in varying amounts until admission. For two weeks she had some nausea and vomiting.

The examination on admission showed a hypertension of 160/100, and a trace of albumin in the urine. The uterus was about the size of a 4 months' pregnancy. Three days after admission, she began bleeding quite profusely. A large hydatidiform mole was removed. Convalescence was uneventful and she left the hospital Oct. 22. The Friedman test was weakly positive.

She was re-admitted four days later because of excessive bleeding which necessitated hysterectomy. Both ovaries were enlarged to the size of oranges.

The pathological diagnoses were: (1) Chorio-adenoma destruens; (2) multiple follicular and lutein cysts of left ovary.

Recovery was uneventful and the Friedman test on December 1, 1936, was negative.

### Summary

1. We have presented a brief review of the current literature on chorioma.

2. The pathology of the ovarian changes

associated with chorioma is discussed in some detail.

3. An outline and review of the present methods of treatment are given.

4. There is included a report of four cases, all of which showed multiple follicular and lutein cysts of varying sizes, three of which were associated with chorioadenoma destruens.

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## CANCER IN AND ABOUT THE MOUTH\*

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Cancer in and about the mouth presents various clinical problems, both in diagnosis and treatment. The day is past when these cases belong under the aegis of one specialty, or entirely to one individual. More than cancer in any other body region, they demand the combined efforts of otolaryngologist, radiologist, surgeon, and pathologist. Large numbers of these patients still die without treatment having interrupted the course of the disease in any degree at all. However, a better balance is being obtained between the accomplishments of different methods of therapy; more cases are being "cured", and there is not the utter hopelessness about mouth cancer that there was a few years ago.

Though certain indications and modes of therapy are now well standardized, in other situations, there is still sharp difference of opinion, and sufficient time has not elapsed for the settling of the pendulum in its swing between surgical versus irradiation methods.

The following cases are presented simply as a short discussion of the problems of treatment. The opinions expressed are based upon our own experience (not large, but extending over several years) plus a perusal of reports published during the past three to four years by those having extensive experience with these lesions.

### Lip

*Case 1.*—Louis P., aged forty-one, was first seen in June, 1931. Patient had been a heavy pipe smoker all his life. In August, 1930, a spike which he was hammering slipped and struck him in the lower lip. It immediately bled severely—then slightly for some several days. An abrasion remained for six months, when he again injured his lip in the same manner. Since then the lesion has spread more rapidly.

*Examination* showed an ulcer 1 cm. in diameter in the middle of the lower lip, extending more on

to the right of midline. It was deep, involving the muscle of the lip.

*Operation* performed June 24, 1931, consisted of a V-shaped excision of mid portion of lower lip. About one quarter of the entire lip was removed. At the same time, the submental, right and left submaxillary triangles of the neck were resected, en bloc.

*Pathology:* Squamous cell carcinoma of lip, grade 2. One lymph node showed early cancer infiltration.

When last seen in January, 1931, six years after operation, the patient was well. There was no sign of any recurrence.

*Summary:* 1 cm. carcinoma of lip with microscopic lymph gland involvement. Well six years after V excision and bilateral submaxillary and submental neck dissection.

*Case 2.*—Harvey S., aged fifty-six, was first seen in September, 1931. Six months before (February, 1931) he first noticed a reddish white area in the lower lip, 0.5 cm. in diameter, to the right of the midline. This spread slowly for four months, then more rapidly in the next two months as a superficial ulcer along the vermilion border, while the original ulcer became deeper, involving the skin of the chin.

*Examination:* Heavy plethoric man. More than three-fourths of the lower lip was occupied by a firm superficially ulcerated growth extending  $\frac{1}{2}$  inch from the right angle of the mouth to within  $\frac{1}{8}$  inch of the left angle. The greatest diameter was toward the right portion, where it formed a hard open ulcer 1 cm. across, with induration extending downward into the lip substance another  $1\frac{1}{2}$  cm.

One small gland was palpable in the right submaxillary triangle. This was felt only by placing the finger in the floor of the mouth and palpating externally against it.

*Biopsy:* Squamous cell carcinoma of lip grade II.

\*These cases were cared for in the City Physicians Office, Shurly Hospital and Woman's Hospital. We are indebted to Dr. J. Frank Kilroy, Dr. B. R. Shurly, Dr. James E. Davis, and Dr. Frances Ford and Dr. Don Beaver of Woman's Hospital for many courtesies. Presented at Staff Meeting, Woman's Hospital, January 13, 1937.



*Operation:* On October 2, 1931, a wide U shaped excision of the entire lower lip was done, with plastic closure by means of lateral flaps (transverse incision  $1\frac{1}{2}$  inches into cheek mucosa) brought together in midline. The angle of the mouth was reconstructed by excising skin triangles from the corners of the upper lip. There was some sloughing of the mid portion of the flap, due to tension of the closure.

Three weeks later both submaxillary and submental triangles were thoroughly dissected out. Two glands in the right submaxillary triangle showed metastatic carcinoma.

*Subsequent:* There has been no recurrence. There was some looseness of the lower lip, which was corrected by plastic operations (Dr. Claire Straith). When last seen in January, 1937, (five and one-half years after O.R.), the patient was working and feeling well. A moustache covered the slight visible deformity remaining.

*Summary:* Extensive carcinoma of lip with glandular metastasis. Well five and one-half years after wide lip excision plus neck dissection.

The original cancer on the lip is often a simple matter to cure. A small growth, 1 cm. or less in diameter, may be treated either by radium or surgery. These old men's lips are loose; V excision produces very little visible deformity and has the advantage of always having an adequate biopsy. However, there are sufficient reports of good results from radium to place it in an equal place.

The very extensive growths, most clinics are agreed, should be treated by wide excision with adequate plastic reconstruction. The closure may be done immediately, or if local recurrence is feared the patient can be watched for several months and plastic repair done later. There is too much sloughing and necrosis if these extensive growths are irradiated (Martin).<sup>6\*</sup>

The in-between lesions, larger than 1 cm., but not too large and bulky, are handled satisfactorily with radium in several series, and with much less deformity than surgery produces. Many surgically trained investigators prefer to use radium in these cases.

Conforming to this thought, we have during the past few years referred several small and moderate size lip cancers for radium or x-ray therapy. However, experiences such as the following make us pause at times.

*Case 3.*—A small lesion (1 cm.) on the right lower lip was seen in May, 1933, and referred for

\*There is frequently a thickening of the vermillion border extending from the side of an epithelioma of the lower lip. This is potentially malignant, and in Figi's experience, is responsible for a certain number of "local recurrences," which in reality are new epitheliomas developing upon leukoplakia adjacent to the site of the original growth. For this reason, he advises superficial excision of this thickened vermillion border at the time of the treatment for the primary lesion.

irradiation treatment. It healed under massive x-ray therapy. One and one-half years later it recurred a short distance to the left of the healed scar. The patient neglected this, and came back to the roentgenologist after six months' delay (December, 1935). It was then one inch across, large and fungating. Radium and x-ray were applied, and during the next ten months he received nine courses of x-ray treatment.

In October, 1936, we saw him for the second time. There was an extensive deep ulcer in the left corner of the mouth and chin, with the mandible exposed and necrotic. There were still no palpable nodes in the neck, and we felt that the growth might yet be resectable with a wide procedure and subsequent plastic. However, the patient died suddenly of hemorrhage from the facial artery.

If irradiation therapy is given to lip cancer, there should be a very careful follow up. Certainly, it should not be persisted in if the growth extends. Very wide resections including portions of the mandible can frequently be done in these cases, and satisfactory plastic closure and freedom from recurrence obtained.

## Tongue

*Cancer Side of Tongue on Basis of Leukoplakia:*

*Case 4.*—Mary D., aged fifty-five, was first seen in February, 1932.

*History:* Twelve months before (February, 1931), she became conscious of a lower right molar tooth irritating the lateral border of the tongue. There was a sharp edge the size of a pencil point, which continually cut into the tongue. She would file the tooth down with a finger nail file each month.

An ulcer was first noted on the under surface of the tongue June, 1931. The offending tooth was removed two months later (August, 1931). There has been no pain or bleeding.

*Examination:* On the right lateral surface of the tongue opposite the first molar tooth, was a lesion  $\frac{3}{4}$  inch in diameter. Its site was at about two-thirds the distance from the tip to the anterior pillar of the fauces. It was covered with leukoplakia. Edge was hard and firm, but there was no extensive induration in the tongue.

*Biopsy:* Showed infected squamous cell carcinoma of the tongue, grade 3.

*Treatment:* On February 18, 1932, hemiglossotomy was done, with sharp scalpel. Radical neck dissection was done at the same time. The neck glands showed hyperplasia—no cancer. The wounds healed with some infection. Speech was restored fairly well.

In January, 1933, she was wearing new upper and lower plates. She was seen January, 1937, five years after operation and is well.

*Summary:* Carcinoma of lateral surface of tongue following leukoplakia. Well five years following hemiglossotomy and neck dissection.

*Cancer of the Floor of the Mouth:*

*Case 5.*—History: John L., aged forty-eight, was first seen in October, 1931. For some time there was a sensation of irritation under the right side of the tip of the tongue, accompanied by a bad taste in the mouth. About July, 1931, he noticed swelling of the tissue underneath the tongue. In August, 1931, there was pain under the right ear.

*Examination* showed a small growth involving the right side of the floor of the mouth, underneath



the tongue, and encroaching on the frenum. There was an ulcer 2 cm. x 1 cm. centering at the orifice of Wharton's duct. It was freely movable, raised, densely hard, but not fixed nor attached to the bone or tongue.

There was a small hard gland just anterior to the facial vessels in the submaxillary region.

*Biopsy:* Early stage carcinoma of tongue squamous cell grade 3.

*Treatment:* On October 24, 1931, six radon seeds were implanted about the growth (1.5 mc. radon, .5 mm. gold filtration). At the same time, radical neck dissection was performed. Right omohyoid jugular triangle, submental, submaxillary glands, jugular bulb region thoroughly cleaned out.

Microscopic examination showed glands negative for cancer.

*Subsequent Course:* He has remained well since. When last seen in January, 1937, five years after operation, there was a small scarcely visible depression where the lesion had been. He was well and working.

*Summary:* Small carcinoma of floor of mouth. Well five years after radon implantation and neck dissection.

Present-day methods of handling the primary tongue lesion are a distinct advance over the former sole reliance upon sharp dissection. Reports of healing of the primary lesion in 50 per cent of the cases are not unusual.

Some authorities (New, Lenz) still prefer to excise lesions which have started from leukoplakia, as in Case 4. Generally speaking, however, sharp dissection is bloody, and in the active muscular organ which the tongue represents, sharp dissection has been replaced by either diathermy excision or interstitial radium. Diathermy seals tissue spaces along the incision (theoretically at least), avoiding cell implanation. There is little or no hemorrhage; there is destruction beyond the actual site of the section, easier access to the lesion and the neighboring bone can be destroyed if necessary. There is, however, more postoperative sloughing.

Radium has the great advantage of preserving function of the tongue, producing healing, in the successful cases, with very little scarring. Interstitial radium needles—low content 0.5-1 millicurie heavily filtered (.3-.5 mm. gold or platinum wall) has produced striking results and good total figures. Some use it for all tongue cancers; others prefer diathermy excision for the larger growths, with perhaps implantation of radon seeds about the periphery. The side of the tongue is probably the most favorable location for cure. Syphilis associated with tongue cancer notoriously offers a poor prognosis. The association of

the two is frequent enough so that a positive Wassermann affords no diagnostic security. The lesions in the posterior portion of the tongue are more active as regards cell type and there is much more lymphoid tissue here, so that the spread of cancer is more rapid. Sometimes bulky metastases are noted before anything is suspected on the tongue. Most authorities treat posterior tongue cancer with interstitial radium. Some surgeons (but the minority) use diathermy — especially for the small growths.

In tongue cancer, there is urgent need for early treatment. It is more important than location (Richards) or perhaps, method. Some cases get out of hand in very short order, as the following case, a not infrequent sequence of events, shows.

*Case 6.*—The patient was first seen by Dr. Mancuso September, 1936.

*History:* At that time he had a pea-sized lesion ( $\frac{1}{2}$  cm.), a hard superficial nodule, underneath the tip of the tongue, on the floor of the mouth centering about Wharton's duct. Though treatment was advised, he did not return to the clinic until December 2, 1936, two months later.

*Examination:* It was then three or four times as large, and ulcerated. There was slight fullness in the right submaxillary triangle, but no glands. Biopsy showed squamous cell carcinoma grade III. He again delayed and did not return for three weeks (December 20, 1936). The lesion then involved the entire anterior floor of the mouth as an extensive ulcerating process. There was a large, hard fixed mass of glands in the right submaxillary region of the neck.

*Summary:* Very rapid extension carcinoma floor of mouth—neglect.

Once gaining a start, especially in the floor or posterior part of the tongue, the spread is very rapid. The quick change from the inconspicuous nodule to the emaciated cancer derelict may not take more than a few months, in spite of any known therapy. Though occasionally radiation accomplishes wonders in such cases, treatment of most of these cases had best be considered as symptomatic care of the far advanced cancer patient: mouth wash, gargles, analgesics, narcotics, fifth nerve injections to control pain, or ligation of the lingual artery in the neck for control of hemorrhage.

## Tonsil

*Case 7.*—William S., aged sixty, was first seen April 29, 1935.

*History:* One year before he noticed an occasional twinge of discomfort in the left posterior mouth region. Three or four months ago this came more regularly. For the past one to two



months it has been worse. He thought the pain was in the teeth and had three teeth removed from the upper jaw, with no relief.

*Examination* showed an ulcer  $1 \times 1\frac{1}{4}$  cm. in diameter in the left anterior pillar of the fauces. It was flat. There was no induration in the depth, and the tonsillar region was otherwise apparently negative. There were no neck glands palpable.

*Biopsy:* Showed well differentiated new growth, squamous cells, many spinous cells, but no pearls.

*Treatment:* In May, 1935, x-ray therapy was given (Woman's Hospital, Dr. Frances Ford). This was completed on May 16. The lesion in the mouth had shrunk, now looking like a small scar. There was no active ulceration.

A few days later, six radon seeds were inserted about the lesion in the left fauces ( $\frac{1}{2}$  mc. each,  $\frac{3}{10}$  mm. gold filtration) (Morphin-hyoscin sedation) on June 20, 1936, block dissection of the left side of neck was done.

*Pathology:* Ten sections checked. No cancer found. Simple inflammation of nodes of neck.

*Subsequent:* On August 6, 1935, there was what looked like a small recurrence, a superficial beginning ulcer at the lower border of the previous lesion in the left anterior pillar region—was noted. This was observed carefully for a few weeks to exclude radium necrosis, and on September 17, twelve radon seeds ( $\frac{5}{10}$  mc. and  $\frac{3}{10}$  mm. gold wall) were inserted in a circle about this recurrent ulcer and downward toward the pharynx. The lesion healed quickly and it has remained well since.

*Subsequent:* Last examination October 1, 1937, showed a well healed pale scar in the left anterior pillar of the fauces. The neck wound was well healed, with very little disability and not much disfigurement.

*Summary:* Carcinoma of pillar of fauces arrested two years—radon implants plus neck dissection preceded by deep x-ray therapy. Radon implants arrest of a local recurrence two months later after original treatment.

Carcinomas of the tonsil are handled much better now than formerly. Many cancers in this location are of high cellular activity. Radon implantation, with external irradiation, either x-ray or radium (bomb), have been quite satisfactory in many clinics. Some (Richards) irradiate externally, and use radon seeds later if this local growth is not controlled. Some authorities prefer diathermy coagulation of the growth. We feel diathermy is preferable for the larger growths, radon seeds for the smaller; but a cancer in this region of any large extent is very difficult to control by any method.

With cancers arising on the gingiva or mandible, radium offers little, according to most authorities. The periosteum is sensitive to radium. The ordinary dose causes bone necrosis, in which the cancer may grow more rapidly.

Cancers inside the cheek do not spread quite as rapidly as tongue cancers do. Diathermy is satisfactory if the growth has not involved the overlying skin or even the

buccal musculature. If more extensive, radium or external irradiation is preferable (Patterson). One method<sup>1</sup> is to lift up a wide external skin flap along the mandible, ligate the facial artery, then coagulate the growth from the inside of the mouth with diathermy.

### Antrum

*Case 8.*—Sidney S., aged fifty, was first seen April 19, 1936.

*History:* Chief complaint was swelling of the right cheek. He has worn an upper plate (denture) for twenty-two years. In January, 1936 (four months ago), he first noted that the pressure of the denture during mastication caused pain in the region of the right antrum and posteriorly. He could not chew on it and had to remove it. About this time there was also slight swelling of the gum margin at the region of the first to second upper molar on the right side.

*Examination:* On April 19, 1936, the right molar region was more prominent than the left. There was slight lid lag on the right eye. There was also slight enophthalmos compared to the left, and the pupil was slightly lower on the right side. Mouth: The right side of hard palate was soft and spongy. This portion of the palate protruded into the mouth, compared to the left side, which was firm and bony. There was also a protrusion of soft tissues  $1\frac{1}{2}$  cm. lateralward into the cheek from the alveolar margin. X-ray showed a large defect in the right antrum with destruction of the floor of the orbit and complete destruction of the floor of the antrum. There was no involvement of the mesial wall on the antrum, nor of the ethmoid cells.

*Operation* was performed May 14, 1936, with avertin rectal anesthesia, 80 mgm. per kilo body wt. supplemented with intra-tracheal gas-oxygen. The pharynx was blocked off. The antrum was entered through the right hard palate where the growth had broken through. Biopsy taken immediately showed grade III small celled carcinoma. The whole antrum was cleaned out with diathermy coagulation. Tissues bled easily and coagulation had to be done slowly. The zygomatic arch of the malar bone was involved in the growth and it apparently had extended toward the cheek. The floor of the orbit also was eroded over a certain area. Mesially there did not seem to be so much extension of the growth. There was a considerable mass of the growth in the posterior palate region, just in front of the pharynx. At the conclusion, 80 mgm. of radium in two capsules (finger cot and 1 cm. of gauze filtration) was packed into the cavity and left in place sixty hours. (Dr. F. Ford) Post-operatively, there was considerable redness and swelling from the radium reaction. Otherwise, convalescence was not painful. The slough of the bony walls of the antrum separated slowly and the cavity became lined throughout its entire extent with smooth mucous membrane. The right eye softened and sloughed (the orbit had been coagulated) but this process ended in a fairly clean upper wall of the cavity.

*Subsequent:* on March 1, 1937 (twelve months after operation), the patient is comfortable, active, has good sight with the left eye. There is a large opening in the front of the antrum, from the eye to the lip. Thru this the antral cavity is visible, also the nasal bones, and the ethmoid cells. There is a bridge of tissue about  $\frac{3}{4}$ " wide, remaining of the upper lip. The entire floor of the orbit and

palate on the right side is gone. Cavity is entirely healed. Dental prosthesis being made to fit into lower portion of cavity, and attach to second appliance from above.\*

Carcinoma of the antrum is not seen very frequently.

Ohngren (1933) has published an exhaustive monograph, carefully analyzing his clinical examinations, operative procedure, and end results in 187 personally treated cases in Holmgren's clinic in Stockholm. Of the 150 cases operated upon 38.5 per cent five-year cures were obtained.

His classification is worth noting: He divides the antrum region by a plane of malignancy from the inner canthus of the eye to the angle of the mandible into an anterior-inferior region, where tumors have greater opportunity to grow outward (malar region, etc.) and posterior-superior region where the growth soon encroaches on the meningeal and vascular stems, hence are clinically much more malignant.

Growths arising on the lower alveolar region, the inner portion of the inferior division, are the most benign. Those high in the ethmoid are the most dangerous, because they soon invade the cerebral cavity. Between these two extremes is a large group, of varying malignancy, depending chiefly on whether growth proceeds outward, toward the malar region, or inward and posteriorly to the ethmoids and meningeal.

He feels that pathological grading adds only about 20 per cent to diagnostic efficiency; for one reason because specimens from different portions of the tumor may show different grades of malignancy. Epithelial and connective tissue growths are not separately classified. He has, after considerable experience, adopted electro surgical coagulation with radium and x-ray therapy frequently added, as his routine treatment.

New, of the Mayo Clinic, has summarized his end results in cases, using the same electro surgical coagulation technic. He reports almost 70 per cent cures in cases traced.

These cancers arising in the antrum, nasal sinus, upper jaw (except if very far

advanced) rarely invade the neck. This fact lulled into a false sense of security in the above case (Case 8).

### Treatment of the Glands of the Neck

*Radiation vs. Surgery: Theoretical Considerations.*—It is in the treatment of the lymphatic drainage areas in the neck that controversy still rages, and the pendulum is far from its ultimate resting place. The camps are divided into: those who advocate irradiation to the entire exclusion of surgery; those who advise prophylactic irradiation and subsequent surgery only if glands become enlarged and palpable; those who advise irradiation in active growths (Grades 3 and 4) and surgery in the others; those who advise surgery followed by postoperative irradiation, and those who feel that irradiation adds little to the prospect of cure, and radical resection should be done in all cases of oral cancer.

For treatment of the neck by irradiation alone and no surgery, the argument is, in brief, about as follows:

There is an appreciable mortality associated with the neck dissection operation. Though this is much less nowa-days than formerly, it is still 15 per cent (Morrow) to 9 per cent (Wookey) in some recently published surgical figures.

Seventy to eighty per cent of lip (Lenz) cancers, perhaps 30 per cent of tongue cancers do not invade the neck if the primary growth is adequately destroyed, so that operating upon all cases would subject many patients who would never develop neck metastases to many needless operations.

There is a definite protective value to irradiation, causing lessened incidence of neck metastases. This is based upon the experimental work of Murphy, of the Rockefeller Institute, in which he found that carcinoma implants in experimental animals took less favorably in irradiated fields. Ewing and others have stressed their clinical observations that fibrosis through the field makes an unfavorable stroma for the growth of cancer cells. The value of irradiation in the actual destruction of cancer cells in the neck is doubted by many radiologists. (See below.)

In favor of delayed block dissection, the reasons given are:

Metastasis to the neck nodes takes place

\*Follow up: On Sept. 1, 1937, a dense hard mass was noted on the lower surface of the mandible, in the posterior upper portion of the submaxillary triangle. Upper, then lower neck dissection was done. Microscope showed metastatic carcinoma invading a few glands in the posterior submaxillary chain.



by embolus, a single node becoming suddenly involved. This node acts as a sieve to the early metastasis, and represents a protective mechanism which is lost if the dissection is performed immediately. Radiologists feel that if a gland is removed sometime later, before the capsule is broken, there is as good chance of cure as if it were not palpable and contained only microscopic cancer. Hence there is no harm in waiting.

Prophylactic irradiation reduces the viability of the cells, so that at the time of handling—if operation becomes necessary—there is less danger of spread. Also a firmer stroma in the lymphoid tissue ensues, which theoretically is more effective in walling in the cancer cells. This latter is the rationale of postoperative irradiation.

The contrary (surgical) opinion is about as follows: There has been too much importance attached to the protection rendered by the cervical lymphatics. "The lymphocyte as it exists in the node is inactive and is capable of functioning only when it migrates into the tissues, just as the polymorphonuclear leukocyte cannot perform phagocytosis inside the blood vessel." (Albright)

It has been shown that the minimum lethal dose for cancer cells in neck glands is 7 to 10 skin erythemas, and the intensity of external radiation in these cases rarely reaches 2 S.E.D., never exceeds 3 S.E.D. Evidence that prophylactic radiation has reduced the frequency of later metastases is difficult to obtain (Albright).

There is a tremendous toll due to delay in these cases. Lip cancer adequately treated early produces 90 per cent or more of cures. With one gland involved, cures are 70 per cent; with two, 40 per cent (Pflueger). In tongue cancers, cures range from 50 per cent to 30 per cent (Morrow, New, Patterson) radically treated if no glands are involved; with glands—15 per cent (New) to less than 10 per cent (Morrow).

Regarding rapidity of spread: almost three-fourths of tongue cancers develop lymph nodes in six months (Morrow). In several series, 50 per cent of the patients with tongue cancers who had been treated conservatively, developed glandular metastases while under observation (Wookey, Hutchison). Furthermore, if the growth is not completely destroyed, the acute in-

flammatory reaction caused by irradiation in these loose, cellular, well-nourished tissues may spread the disease.

All who have controlled their clinical judgment admit an error ranging from 20 to 30 per cent to 50 per cent in palpating whether a node is inflammatory or cancerous; hence determining when a node is malignant is elusive.\* Because of this fact, some surgeons feel it is difficult if not impossible to compare surgical statistics, in which exact microscopic examination of the nodes was done, with radiologic end results, where the only information available is whether or not the node was palpable (Quick).

Advocates of frequently performed and radical neck dissections feel that in a disease so invariably fatal if left alone, it is worth while doing many dissections to attempt the cure of those who will have metastasis, or already have them perhaps microscopically (Figi, Fischel). This is the same attitude as is taken in breast cancer, where routine axillary dissections are the rule.

*Present Practice.*—Irrespective of theory, current practice is about as follows: Undoubtedly the pendulum has swung toward watchful waiting and radiation, especially in the earlier cases, rather than extensive dissections (Albright quoting Berven, Cade, Duffy, Jacoby, Quick, Stewart and others). Many fewer neck dissections are done now than ten or even five years ago.

Albright sent questionnaires to twenty-five or thirty of the leading cancer clinics throughout the world. He concluded that two-thirds to three-fourths of present-day clinics are satisfied to treat the neck conservatively if no nodes are palpable. This is especially true of lip cancers, many of which (Grade 1) develop neck metastases so rarely that many more authorities are satisfied to leave the neck alone surgically than formerly.

"Conservatively" generally means prophylactic irradiation, but not always. Some leave the neck entirely alone and watch and wait.

If nodes are palpable, most authorities prefer adequate dissection, which means

\*"Nodes showed microscopic involvement in only one-half of the patients with clinically palpable nodes, and in one-third of those without clinically palpable nodes" (Morrow). "In early glandular enlargement, it is almost impossible to determine whether it is due to inflammation or neoplasm, especially as the majority of the primary lesions are associated with obvious infection" (Wookey).

complete block for tongue, submental and submaxillary dissection down to the hyoid level for lip. This is generally (but not always) followed or preceded by external irradiation. Quick's view, that palpable nodes should be explored surgically and sterilized with radium implants (Morrow), does not seem to have attracted many adherents. Very old persons, and those with fixed, hard masses are spared operation—perhaps more frequently than in former years. Since Coutard therapy has become more popular there is an increase in the opinion that prolonged low intensity radiation carefully given should replace all surgery. There is also a growth of contrary opinion: that radiation cannot cure neck cancer, and there should be a "more ready resort to prophylactic dissection"—because the cure rates for intra-oral cancer after neck metastasis has occurred are so much lower than those without metastasis (Wookey, Hutchison, New). In some places (notably The Mayo Clinic) active cellular growths in the tongue—Grade 4—are irradiated and neck dissections not done, or only occasionally performed.

We note two trends in recent reports: (A) A feeling that many lip cancers are of low grade, metastasize infrequently if the primary is adequately treated—hence fewer dissections for lip cancer. (B) An increasing respect for the gravity of tongue cancer, and the large number who develop glandular metastases while under treatment—hence more and earlier neck dissections. The mortality from neck dissections for tongue cancer is due chiefly to combining intra-oral and neck surgery at the same time, thereby opening fascial planes, or from cancers in the floor of the mouth. The present mortality rate should be reduced.

As to our own opinion in the matter of neck dissections, no routine and positive position has been reached. It is sometimes difficult or impossible to compare different sets of statistics, with the variable personal equation, variations in material, classifications, etc., that one notes in articles on the treatment of intra-oral cancers. Personally, we are not dogmatic, and confess to a certain indecision at times. The neck dissection, especially for tongue cancer, is a formidable procedure, and though not ac-

companied nowadays with as high a mortality as it formerly was, nevertheless is not to be undertaken lightly if a far simpler method is adequate. But that is still open to proof in our opinion, and, apropos of this present trend toward conservatism in neck dissections for oral cancer, a few personal experiences stick fast in our memory. The following two examples are typical of others.

*Case 9.*—An old man, in whom we removed a small lip cancer with V-shaped excision and had x-ray therapy given to the neck. There was a small gland palpable behind the left submaxillary gland, which we observed at intervals. About one and one-half years later, the gland increased, soon ulcerated, and he went through a very painful six months' illness before death from cancer. We have always felt that neck dissection done immediately should have given a better result.

*Case 10.*—A man, aged fifty-eight, gave a vague history of having had a lip lesion treated with carbon dioxide snow, later a small amount of radium, seven or eight years ago. He did not know the nature of the lesion himself and no record could be obtained. The lip was absolutely negative. There was a hard nodule, the size of a dime, overlying the ramus of the mandible on the right side, at the site where the facial vessels cross the bone. We thought it to be an alveolar dental abscess. After some weeks observation a second biopsy showed metastatic squamous carcinoma.

The difficulty, and danger, in our opinion, of conservative treatment of the neck in these cases is that the ironclad follow-up which is so essential is frequently so difficult to carry out in actual practice that the patient loses his chance of cure. This has been commented on by several recent writers (Hutchison, Albright).

Regarding tongue cancer, we have seen some of our own cases and those of other surgeons flare up six months after carefully performed neck dissections—sometimes with diffuse multiple skin nodules as if a match were touched to the disease. We felt that some of these patients would have lived longer had they been left alone. Active anaplastic growths (Grades 3 and 4) we are inclined to leave alone—refer for prolonged Coutard irradiation. Tongue cancer, however, is such a formidable disease, that we think more early thorough dissections should be done in the growths showing better differentiated cell type. For the others, palpable neck nodes, we think, call for radical block dissection perhaps followed or preceded by x-ray therapy. With no nodes palpable, we have been content at times with irradiation and no surgery, but



are quite concerned when we make that decision, and this may not be our final opinion.\*

### Summary

Ten clinical cases, illustrating various problems in the management of cancer in and about the mouth are described, and the present trends in the treatment of these conditions are discussed.

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Surgery as applied to lymph nodes of the neck in can-

\*For several years we have followed Semken's technic in all our neck dissections. It is a strictly anatomical dissection of all the neck lymphatics, with meticulous attention to detail and hemostasis, profound regard for the "cancer field" and the danger of crossing it, and care to keep the dissection beyond the growth. For the upper neck dissection: The flaps are elevated. The field is outlined, starting beneath the mandible in front of the parotid. The lower pole of the parotid is cut across. The sternomastoid is cleared, taking away its fascia. Dissection is started at the omohyoid crossing in the mid neck, and this region freed up—leaving the fat pad of the larynx as a floor. The submental submaxillary triangles are systematically cleared, the jugular bulb traversed, clearing the fascia away from the vein, the posterior neck fat and lymphoid tissues behind the carotid artery dissected away and the return to the original omohyoid sternomastoid angle accomplished. Here the lymphatic connection with the lower posterior neck triangle above the clavicle is only  $\frac{3}{8}$  inch thick. The lower triangle is usually left for a second operation.

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## OCCUPATIONAL SKIN DISEASE\*

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In the field of medicine, the last fifty years have been filled with many epoch-making advances. To read the history of this period is to be thrilled by medical adventures such as have not been seen since the dawn of modern medicine. Dermatology, as a highly specialized field in medicine, has shared in these advances and we have been privileged to observe and participate in the changes taking place in our field. We have witnessed the advent of the x-ray for skin therapy, its crude dosage estimation replaced by scientific, easily duplicated international units. In the field of physiotherapy we have seen the increased use of radium, ultraviolet rays, and high frequency surgery. We have seen the pendulum swing from hyper-enthusiasm to a common-sense dosage application.

Medically, the fascinating field of allergy and sensitization has given us a glimpse of its enormous possibilities in dermatologic etiology, and other fields of medical re-

search have been leading to the correlation of various skin syndromes to internal diseases. Endocrinologists, bacteriologists, pathologists, chemists, internists, and surgeons, all have added to our knowledge and we have built up a literature whose significance will stand for many decades to come. All of these findings form fascinating reading, but one of the most exciting of the newer fields to open to the derma-

\*President's address, Dermatologic Section, Michigan State Medical Society, Grand Rapids, Mich., September, 1937.

TABLE I

Awnings, tents, sails, and canvas covers.....	12	Miscellaneous articles not elsewhere classified...	6
Beverages (non-alcoholic).....	28	Models and patterns, not including paper pat-	28
Bookbinding and blank-book making.....	12	terns .....	28
Boxes, wooden, except cigar boxes.....	9	Motor-vehicle bodies and motor vehicle parts ...	61
Bread and other bakery products.....	252	Motor vehicles, not including motorcycles .....	24
Brooms .....	5	Nonferrous-metal alloys and products, except	
Brushes, other than rubber.....	4	aluminum, not elsewhere classified.....	40
Butter .....	5	Paints and varnishes .....	23
Canned and dried fruits and vegetables, pre-		Paper .....	4
servees, jellies, fruit butter, pickles, and sauces..	9	Paper goods, not elsewhere classified.....	9
Caskets, coffins, burial cases and other mortician's		Patent or proprietary medicines and compounds..	20
goods .....	7	Photoengraving, not done in printing establish-	
Cigars .....	11	ments .....	14
Clay products (other than pottery) and non-		Planing-mill products (including general mill	
clay refractories .....	3	work) made in planing mills not connected with	
Clothing, women's, not elsewhere classified.....	6	sawmills .....	26
Compressed and liquefied gases .....	8	Printing and publishing, book, music and job...180	
Concrete products .....	11	Printing and publishing, newspaper and periodical.70	
Confectionery .....	14	Pumps (hand and power) and pumping equip-	
Cotton goods .....	3	ment .....	7
Electrical machinery, apparatus and supplies....	29	Sausage meat puddings, headcheese, et cetera,	
Electroplating .....	22	and sausage casings, not made in meat-packing	
Engines, turbines, tractors, water wheels and		establishments .....	25
windmills .....	7	Screw-machine products and wood screws.....	29
Feeds, prepared, for animals and fowls .....	3	Sheet-metal work not specifically classified.....	23
Flavoring extracts and flavoring sirups.....	7	Signs and advertising novelties.....	25
Flour and other grain mill products.....	5	Smelting and refining, nonferrous metals other	
Food preparation, not elsewhere classified.....	12	than gold, silver, and platinum, not made from	
Forgings, iron and steel, not made in plants oper-		the ore .....	7
ated in connection with steel works and rolling		Stamped ware, enameled ware, and metal stamp-	
mills .....	10	ings, enameling, japanning, and lacquering....	31
Foundry and machine-shop products, not else-		Steam fittings and steam and hot-water heating	
where classified .....	143	apparatus .....	11
Foundry supplies .....	4	Stereotyping and electrotyping, not done in print-	
Fur goods .....	12	ing establishments .....	6
Furniture, including store and office fixtures....	18	Stoves and ranges (other than electric) and	
Grease and tallow, not including lubricating		warm-air furnaces .....	7
greases .....	4	Structural and ornamental metal work, not made	
Ice cream .....	17	in plants operated in connection with rolling	
Ice, manufactured .....	28	mills .....	26
Jewelry .....	12	Tools, not including edge tools, machine tools,	
Knit goods .....	7	files, or saws .....	3
Liquors, malt .....	14	Wall-board, insulating board, gypsum and other	
Lubricating oils and greases, not made in petro-		plasters, and other floor composition.....	5
leum refineries .....	4	Waste processed .....	5
Machine-tool accessories and machinists' precision		Window shades and fixtures .....	7
tools and instruments .....	108	Window and door screen and weather strip....	7
Machine tools .....	9	Wirework, not elsewhere classified.....	18
Marble, granite, slate and other stone products..	10	Wood turned and shaped and other wooden	
Mattresses and bed springs, not elsewhere classi-		goods, not elsewhere classified.....	3
fied .....	6	Wrought pipe, welded and heavy riveted, not	
Meat-packing, wholesale .....	16	made in plants operated in connection with	
Mirror and picture frames .....	3	rolling mills .....	5
Mirrors and other glass products made of pur-		Other industries .....	333
chased glass .....	4		

tologist is the field of industrial dermatology. Each new invention in the commercial and scientific field has led to the creation of new industries and, with their establishment, new problems among the workers. Industrial engineers were created to solve these problems, but it was soon found that, without the physician, these problems were unanswerable, and that the cost to industry in accidents, illness and loss of man-power time was tremendous. With the growth of a social consciousness and the institution

of compensation for injury and loss of time, industry began to call on the medical profession for aid in the solution of these problems.

The recognition of the effect of occupation on the skin dates back to Ramazzini and Potts—1700 and 1775—but it was only in the last thirty years that interest began to be widespread and important contributions to the literature were made by men like R. Prosser White, O'Donovan, Gardner, Ullman, Oppenheim and Rille, Pusey,



## OCCUPATIONAL SKIN DISEASE—SCHILLER

TABLE II. DETROIT INDUSTRIES REPORTING INDUSTRIAL DERMATITIS

No. of Plants	Products Manufactured	Known Hazard	No. of Plants Affected
4	Air Compressors & Pumps	Cutting Oils, conning oils	1
39	Aircraft & Allied Products	Cutting oils, gasoline, chromic acid, paints and varnishes, muriatic acid, cyanide, silicate of soda, rubber accelerators.	14
5	Babbitt Metal & Solder	Muriatic acid	1
9	Bearings & Bushings	Cutting oils, gasoline	3
6	Brass, Copper Sheet, Wire Rod, Tube & Pipe	Drawing Compounds	1
36	Brass Goods—Hardware Supplies	Cutting oils, gasoline, paint	2
42	Building Products, Miscellaneous		
18	Building Products—Structural Steel	Red Lead	3
20	Castings, Aluminum, Bronze & Alloy	Cyanide, lime, cutting oils	3
28	Castings—Iron & Steel	Cyanide, gasoline, paint	2
32	Cement & Concrete Products	Lime	3
2	Chains	Petroleum Oils	1
80	Chemical Products	Salt, synthetic wax, detergents, rust-proofing, petroleum oils, petroleum solvents, carbon tetrachloride, carbon, caustic soda, paint remover	11
27	Clothing, Furs	Fur Dyes	2
10	Clothing, Women's	Dyes	1
12	Electrical Apparatus, Controls & Devices	Motor oils, chromic acid, Synthetic wax.	3
8	Electrical Appliances, Household	Chromic acid	2
16	Electrical Goods, Transformers, switches	Paint, transformer oils, synthetic wax	4
5	Engines (combustion)	Gasoline	1
30	Engraving (Photo)	Ammonium Bichromate	3
21	Foods (Beer)	Carbon tetrachloride, Naptha	2
16	Foods (Candy)	Sugar	1
55	Foods (Dairy)	Caustic Soda	5
10	Foods (Meat Products from Packing Houses)	Salt, intestinal fluids	5
14	Forgings	Cyanide	1
4	Gaskets	Asbestos	1
5	Heating Equipment (oil)	Gasoline, paint	2
3	Heating Equipment (radiators)	Kerosene	2
11	Heat Treating	Cyanide	1
18	Laundries (Cleaners & Dyers)	Gasoline, carbon tetrachloride	6
14	Lithographing	Ammonium bichromate	2
54	Machinery & Tools	Mineral oil, gasoline, cutting compounds, chromic acid	3
36	Machinery & Tools (General Machine Shops)	Cutting Oils	1

## OCCUPATIONAL SKIN DISEASE—SCHILLER

TABLE II—*Continued*

No. of Plants	Products Manufactured	Known Hazards	No. of Plants Affected
19	Motor Vehicles	Mineral oils, gasoline, naptha, carbon tetrachloride, chromic acid, muriatic acid, cyanide, paint, enamels, cutting oils, synthetic enamels	9
7	Motor Vehicle Bodies	Paint, Drawing Compounds, Oils,	4
17	Motor Vehicle (Hardware)	Chromic acid, gasoline, cutting oils, cyanide, lime	5
20	Motor Vehicle (Engine parts)	Gasoline, oils, naptha	5
16	Motor Vehicle (Gears, Axles, Transmissions, etc.)	Gasoline, oils, naptha	7
6	Motor Vehicle (Springs)	Chromic acid, oils	3
2	Motor Vehicle (Radiators)	Muriatic acid	2
18	Motor Vehicle (Cushion Springs & Trimmings)	Sodium silicate, oils, paints, chromic acid	3
1	Office Equipment, mechanical	Inks, paints	1
6	Oils & Lubricants	Oils and paints, sulphuric acid	2
26	Paints, varnishes, lacquers	Thinners, paints, turpentine, lead	1
2	Paper & Paper Products	Bleaches	1
32	Plating & Polishing	Chromic acid, sulphuric acid, copper plating, cadmium	3
12	R.R. Materials & Repair Shops	Oils, greases	2
4	Salt	Salt	1
30	Screw Machine Products	Cutting oils, gasoline	7
34	Sheet Metal Works	Sulphuric acid	3
28	Stampings & Auto Specialties	Drawing Compounds	2
18	Steel & Steel Tubing	Gasoline, lime, oils	3
16	Trailers	Oils, paints	2
13	Window Shades	Paints, oils	1
18	Wire Products	Chromic acid, drawing compounds	4

Shamberg, Cole, Oliver, Forester, Eller, Schwartz, and many others. The United States Public Health Service felt that the field was of enough importance to create a special bureau of investigation and much work of importance has emanated from this source.

Schwartz, in a recent talk, gave some interesting statistics. He said that sixty-five per cent of occupational diseases were dermatoses, that the average cases lost ten weeks time from work, and that the annual cost of occupational dermatoses was estimated at four million dollars per year. His list of possible industrial skin irritants

seems fairly complete, and yet one can not help but feel that the surface has barely been scratched.

Scholtz, in an interesting recent article, has pointed out that two major factors determine the type and intensity of the skin reaction in an affected individual. First—the biologic makeup and resistance of the individual skin; second—the character and intensity of the occupational irritant. He classified the various “ergo dermatoses” as (1) infectious; (2) pyogenic; (3) systemic.

He feels that the diagnosis of “ergo dermatoses” cannot be made on morphology



alone, but on the combination of careful history taking, patch testing, and a recognition of all the various factors that might make for a correct interpretation.

A thorough review of the literature tends to prove that there are few occupations which are entirely exempt from occupational skin diseases and, while certain industries are greater offenders in this respect than others, it seems to me that all industries would profit from a thorough survey of the conditions that might produce dermatoses in their plants. Eller and Schwartz classify the general causes of industrial dermatoses as follows:

1. *Physical Agents.* Burns, scalds, extreme cold, radiations of ultraviolet light, heat, roentgen rays and trauma.
2. *General Irritants.* These are agents which will irritate any skin. A direct, predictable, toxic effect is possible with these chemicals. The inorganic general irritants can be subdivided into acids, strong alkalis, and caustics. The organic irritants can be divided into acids and solvents.
3. *Specific Irritants.* These do not affect everyone, but cause skin lesions in a considerable percentage. A partial list follows:
  - a. Oils and greases, such as lubricating, vegetable and essential oils.
  - b. Dyes. Certain of the anilin dyes, such as paraphenyldiamine, malachite-green, crystal-violet, bismarck-brown, auramine, and the intermediates and decomposition products. Some of these intermediates which are very irritating are: dinitrochlorbenzol, phenylhydrazine, phenylglycine, anthracene and benzidine.
  - c. Explosives, such as tetryl, T.N.T., lead azide, lead styphnate, fulminate of mercury, et cetera.
  - d. Rubber accelerators, such as hexamethylene-tetramine, tetramethylthiuramediasulphide.
  - e. Rubber antioxidants, such as phenylbetanaphthylamine.
4. Many plants are irritating to certain individuals. Among the most common plant irritants are oak, sumac, ivy, pyrethrum, cocobolo, Brazilian walnut, primrose and chrysanthemum.
5. *Biological Agents.* These may be divided into:
  - a. Parasites, such as those which cause grain itch, straw itch, and linseed itch.
  - b. Bacterial infections, such as erysipeloid, common among butchers and caused by the bacillus of swine erysipelas, glanders and actinomycosis.
  - c. Fungus infections, such as *Monilia* infections, occurring on the hands of fruit packers, and ringworm infections of the hands and feet, common among barbers, wool-sorters, animal handlers, and bath attendants.

In checking the industries in our own city we find that the Detroit Industrial area has over two thousand manufacturing establishments, and the 1933 census of manufacturers shows that the number of wage earners, at that time, were 202,950, with annual

wages paid of \$218,714,818. These produced about one and a half billion dollars worth of products. With the recession of depression conditions, these figures are materially higher. The variety of industries is surprising and, in addition to the automotive industry, we have charted the most important of these.

It is perfectly obvious (Table I) that, with such a variety of industries, the number of factors which might produce dermatoses are almost innumerable. A partial survey of plants reporting dermatoses is shown (Table II), and here we find that, out of 953 plants, 164 reported various forms of industrial skin disease. No doubt many more are affected, but, owing to the compensation situation at the present time, a large number failed to report. We found that cutting oils, gasoline, acids, paints, rubber accelerators, synthetic waxes, solvents, and alkalis accounted for a large share of the complaints.

Naturally, this research is just beginning and we hope to have a more detailed study later on. However, this gives some idea of the magnitude of the problem.

From the above research we can see that the dermatologist, to be of value to industry, must learn to know industry and its hazards, the kinds of chemicals used and their probable effects on the skin, various types of machine processes, working conditions, and engineering problems. He must be trained in a school of diagnosis and have a thorough grounding in internal medicine, allergy, and medical mycology. When fully equipped with such knowledge, the dermatologist can be of service in the treatment of industrial dermatoses in the following ways:

1. In consultation with industries, to train the physicians and nurses in the front-line trenches of industry to recognize the type of individual who is least resistant to industrial hazards.
2. To recognize the onset of sensitization and advise as to treatment, or change of occupation.
3. To consult with industrial engineers in the bettering of working conditions.
4. To treat, efficiently, those individuals who are affected so that there will be a minimum amount of time lost to the individual, and a lowering of the cost to industry.
5. To aid in the formation of laws for the protection of the worker.

This sounds like an ambitious program, but one which the well-trained dermatologist can undertake with the expectation of success.

## NEUROFIBROMATOSIS

### Von Recklinghausen's Disease

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Isolated instances of neurofibromata are not infrequently discovered in a number of cases; but a widely distributed neurofibromatosis throughout the entire body is very rarely encountered. The incidence of a generalized neurofibromatosis is, according to various sources and authorities, one in ten thousand. As the name implies, it is a neoplasm or series of neoplasma harboring both fibrous and neural elements. Four types are recognized:

A. The sessile tumor that exhibits a peculiar lilac tint and is firmly attached to the underlying structure.

B. The empty, sacculated tumors that possess pedicles and may be seen to be lightly attached to the surface of the skin.

C. The raisinlike tumors, small and diminutive in size, studding the surface of the skin. Their color resembles that of a raisin.

D. The forerunner of these growths in the form of pigmented areas seen in various locations of the body's surface. All the four may simultaneously co-exist in the same individual.

The etiology of neurofibromatosis is rather obscure. A familial tendency was established in a few cases, as gathered from the literature on the subject. In one of my cases, the patient's mother was operated for uterine fibroids; yet we cannot place absolute reliance upon such a questionable hereditary factor.

Some observers have found pathologic evidence in the anterior pituitary lobe as ascertained by radiographic examination. Recently the suprarenal glands have been drawn into accountability in the formation of these growths, in view of the pigmentations preceding the onset of these lesions. And thus suprarenal cortex or cortin has been administered in these cases in the hope of either preventing or arresting the progress of this disease, but with no appreciable change in its course.

These neoplasms occasionally assume enormous proportions, so that their size and interference constitute great inconvenience. Surgery in these cases calls for their excision or enucleation. The number of growths present in a patient may reach in the hundreds and at times may be so numerous that they cannot be counted.

At this juncture it may be remarked that the gradual appearance of pigmentary spots in areas which do not lend themselves to

the classification of diseases of pigmentation, must be viewed with suspicion, as the possible precursors of neurofibromatosis. I have seen several instances in women in whom slowly and progressively the various types enumerated before culminated from pre-existing pigmentation.

Some of the authorities lay too much stress upon the concomitant low mentality of the individual so afflicted, claiming that in a great majority of cases feeble-mindedness and inferior forms of mentality have been observed. On the contrary, I have seen people affected by that disease exhibiting a high degree of intelligence; hence the coincidence of low mental types is a factor not to be taken too seriously.

#### Differential Diagnosis

The pigmentary type that may usher in the stage of tumor formation might be mistaken for several diseases of skin pigmentation: notably, cholasmata and tinea versicolor. The former, however, have their location mainly on the face, while the latter may be seen on the chest and back. Microscopic examination of the scales of the latter dermatosis reveals the *microsporon furfur*, which is readily detected microscopically. The pigmentation concomitant with Addison's disease can be positively ruled out when one considers the profound asthenia and the blood picture.

At this juncture it may be stated that in all cases of neurofibromatosis there is an increased eosinophilia, as much as 15 to 20 per cent, which, however, is a common characteristic of all chronic dermatoses.

#### Therapy

Our successes are very limited. Extirpation of the tumors when they reach enor-



mous sizes is the *only procedure*. However, if the various types are found in one individual distributed over a wide area of the body, the problem is not so simple. Antuitrin has been tried by dermatologists with little or no success. Cortin (cortex of the adrenal glands) has also been used with negative results. Roentgentherapy is perhaps the only logical measure that suggests itself. When the growths are widely distributed, however, one must take care not to use an overdose, nor to expose too large an area of the body surface. Moderately sized zones should be selected and radiated at intervals of five days, from  $\frac{1}{2}$  to 1 dermatit, so that in the course of five or six seances all the neoplasms will have been rayed, which procedure may be subsequently repeated, if necessary. In conjunction with this, both antuitrin and cortin may be used. *En passant*, it may be remarked that in many cases of neurofibromatosis there is a low systolic blood pressure; hence the theory promulgated by some, that the adrenals might be responsible, may contain a kernel of truth. Notwithstanding all our attempts at successfully attacking these lesions, the *prognosis* remains very unfavorable and the outlook therefore most discouraging.

### Case Reports

*Case 1.*—F. W., aged thirty, laborer, consulted me August 7, 1936. His family history revealed that his mother had uterine fibroids, which were removed. His past history disclosed the ordinary diseases of childhood, such as scarlet fever, measles, and whooping cough.

*Present History:* The duration of the lesions was three years; although perhaps they might have existed longer than that, without the patient being aware of it.

The dermatosis is located on the trunk, upper and lower extremities, some on the neck, and behind the

ears. Inspection disclosed numerous tumors, some of them very small, and some the size of 2 to 3 cms. A number of them were pigmented and resembled raisin-like lesions. Almost the entire body was studded with these neoplasms. There were also pigmented areas here and there over the trunk without tumor formation. Some of the lesions were sessile, some pedunculated, while other lesions displayed vacuous sacculation.

Serological test was negative for Kahn; the blood count was normal, and the urinalysis negative. His blood pressure was systolic 118, diastolic 60.

*Diagnosis:* Multiple neurofibromata. Treatment was begun on August 10 with roentgentherapy anteriorly and posteriorly, at intervals of 5 days and continued to November 7. In conjunction with radiotherapy, suprarenal cortex and anterior pituitary were administered. During the month of October, it was noticed that the raisin-like, diminutive tumors exhibited signs of retrogression; no effect was noted on the larger tumors nor on the pigmentation. The patient was advised of the unfavorable prognosis but insisted that treatment be carried on for the above length of time.

*Results:* Partly favorable to the raisin-like lesions, while negative to the larger tumors.

*Case 2.*—Mrs. R. S., aged twenty-five, stenographer. Both parents are living and well. The patient had the usual childhood diseases and also sinusitis, for which she had 8 operations, including also tonsillectomy and turbinectomy.

*Present History:* Pigmentation on back from eighth dorsal to the coccyx. Several zones form a chain in the shape of a horseshoe. About eleven or twelve areas are pigmented on the left side of the vertebral column. Blood pressure 110/70. All laboratory tests were negative with the exception of a trace of sugar in the urine.

*Diagnosis:* Pigmentary type of neurofibromatosis. The treatment consisted of radiotherapy, suprarenal cortex and anterior pituitary. Radiotherapy was carried on from 8/10/33 to 2/9/34.

*Results:* The pigmentary areas exhibited a lighter shading. There was no tumor formation at any time. The internal medication was continued for some time after. The patient did not report subsequently for another examination.

*Case 3.*—Miss E. H., aged twenty-three, single. Family and past history was not ascertained as I saw her only casually. Inspection revealed a generalized dermatosis throughout the body consisting of two types: viz., the pigmentary and raisin-like type. But as she did not come under my direct observation, I do not know of the ultimate outcome of the case.

654 Maccabees Bldg.

### "Benzedrine Sulfate" In Enuresis

Molitch and Poliakoff (Arch. Pediat., 54:499, Aug., 1937) recently investigated the effect of "Benzedrine Sulfate" (benzyl methyl carbinamine sulfate, S.K.F.) in enuresis.

Twenty-two nightly offenders, from nine to seventeen years old, were isolated and first given inert placebos. Eight boys, or 36 per cent, remained "dry" with this psycho-therapeutic treatment. Those who continued "wet" were given "Benzedrine Sulfate" in a 2.5 mg. dose, increased where necessary to as high as 20 mg. Two unstable children failed

to respond to treatment, even when the dosage was greatly increased.

Of the twelve boys who remained "dry" with "Benzedrine Sulfate," eight wet their beds the first night placebos were substituted. Two weeks after the discontinuance of therapy, whether with "Benzedrine" or placebo, all the boys had reverted to former habits. Insomnia was the only unfavorable reaction observed, and this was easily checked by decreasing the dose. Urinalysis remained negative throughout.

"Benzedrine Sulfate" is of apparent value in certain cases of enuresis. The authors suggest that the dose be decreased and eventually eliminated when night continence is established.

## ANIMAL EXPERIMENTATION

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MORE than any other method, animal experimentation has provided medicine with a sound scientific background. Through it, hundreds of advances have been made without dangerous experimentation upon human beings. Though limited experimentation on patients has given information of tremendous practical value, it often lacks certainty and acquires its value in relation to a physiological background derived by other and more exact methods.

From time to time, it has been suggested that rigorous experiments might be performed upon criminals condemned to death, that is, on healthy persons whose criminal activities have deprived them of the rights of free men. The kings of old Persia are said to have released criminals to physicians for vivisection. According to Galen, Attalos III, Philometor (137 B.C.), king of Pergamum, experimented on poisons and their antidotes on condemned criminals. Celsus recounted the vivisections performed at Alexandria by Herophilus and Erasistratus upon criminals with the assent of the Ptolemys. Such vivisections were said to be made in order to find the differences between living and dead structures and to ascertain the peculiar types of pain characteristic of various organs. The Grand Duke of Tuscany turned over to Fallopius, Professor of Anatomy at Pisa, a criminal who had a quartan fever. Fallopius attempted to determine the effect of opium on the paroxysm and the man died at the second treatment. Then, there is the story of an archer at Moudon who was given his freedom following a successful experimental nephrectomy.

Though rare and sporadic cases of experimentation on criminals have been reported, physiology has been advanced in no significant way by the method. Condemned criminals form too small a group for convenient selection of subjects and controls for radical or crucial experiments. Humanitarian, moral and penal considerations likewise render the issue practically unimportant from a medical or physiological viewpoint.

Human experimentation has given information of utmost value, but the bulk of it has been done upon the experimenters themselves or upon their friends and students or other volunteers. Anyone acquainted with modern physiology will recall such experiments as Head's sectioning of a large nerve in his forearm to study the loss of and rate of return of sensation to his hand, Carlson's leaving inflated rubber balloons in his stomach for long periods to study hunger sensations, and Barcroft's experiments on himself, inhaling carbon monoxide gas until his assistants dragged him from the inhaler before he collapsed, and again his remaining naked at freezing temperatures to observe the effects of exposure.

The earlier literature also shows that the experimentation of physiologists upon themselves is no recent development. Sanctorius made repeated weighings of himself to study the insensible loss in weight due to breathing and perspiration while subjecting himself to various diets. Spallanzani swallowed little cloth bags containing food, later pulling them from his stomach by attached threads and studying the extent of digestion. Anton von Störk and Alexander studied the effects of various drugs on themselves and on other normal persons. Morton, Wells, Long and Simpson observed the effects of anesthetics upon themselves. Professor Munch of Odessa injected into his own veins blood of a patient suffering from relapsing fever and a few days later developed characteristic symptoms. Karl Gerhardt demonstrated the transmission of malarial fever by injecting blood from an infected patient into himself. J. L. Guyon similarly injected blood from yellow fever patients and cholera patients. Max von Pettenkofer swallowed a fresh cholera culture to see if the disease could be contracted, and Metchnikoff with two assistants repeated the experiments.

Some experiments on volunteers have become almost legendary in their relation to physiological and medical advance. The fistulous Alexis St. Martin, through his co-operation with Beaumont, provided a turning



point in the physiology of digestion. The heroism of Walter Reed's soldier volunteers who assisted in experiments on yellow fever has been dramatized on stage and radio. Likewise, there are many medical students who have willingly submitted to the indignities of the stomach pump, to giving blood samples, urine or saliva after experimental procedures.

Such experiments have a dramatic appeal and serve to emphasize the utter earnestness of physicians and physiologists, and their devotion to principles which they consider important. Often, they give information more convincing than that derived from other sources. Still, the method of human experimentation has its limitations.

The study of many animals is far more important. The natural habits, behavior, diet and structure of various animals differ from species to species. Warm-blooded and cold-blooded, active or inactive, carnivorous or herbivorous, aquatic or land forms provide varied conditions of life. Information derived from an intelligent selection of appropriate forms is of greater value than that obtained from any one form, human or other. Accordingly, the method of animal experimentation has become the fundamental method of physiology, and increasingly from decade to decade, it has become an all-important adjunct to scientific medicine in all of its subdivisions.

Effective use of the method of animal experimentation involves thoughtful planning of experiments and controls, careful selection of an animal type best adapted to the purpose of the experiment and meticulous execution of operative and experimental procedure. Such rigorous standards for animal experimentation, however, have developed gradually.

Galen was the foremost experimenter upon animals during ancient times. He was preceded, however, by Alcmaeon, by Herophilus and Erasistratus of Alexandria and, to a limited extent, by the Hippocratic school. Galen's observations upon living animals were made chiefly upon apes and pigs. By tying a double ligature around an artery and incising the wall of the vessel between the two ligatures, he proved that living arteries contain blood and not air as had been thought by his predecessors. He observed the pulsations of the heart and

arteries; he studied the movements of the epiglottis and larynx; he noted the contraction of muscles, the movements of the stomach and the opening and closing of the pyloric valve. In an experiment on the spinal cord, Galen outlined the technic of tying the animal and the preliminary dissection to uncover the cord. He recounted the effects of longitudinal incisions and of transverse cuts through various levels of the spinal cord. He knew the effects of cutting the recurrent and hypoglossal nerves. He devised a number of experimental procedures upon the respiratory mechanism, cutting the intercostal nerves and muscles and puncturing the pleural sacs.

The physiological approach was simple and direct, and Galen regarded it as an important accessory to anatomical studies. Though promising, Galen's use of experimental physiology was overclouded by the speculative humoral physiology and by conclusions depending upon the dissection of dead animals alone. His great interest in doctrine and speculation made him known as a medical theorist rather than as a physiologist.

Following Galen, vivisection fell into disuse. The Moslem heirs of Greek and Roman medicine disclaimed for religious reasons the study of animals either living or dead, and it was not until long after the introduction of classical medicine into Europe of the Renaissance Period that vivisection was practiced again.

In Vesalius' great anatomy, the last chapter was devoted to the dissection of living animals. Vesalius described the character of living bones, ligaments, muscles, nerves, blood vessels and organ systems. He told of the effect of ligating or cutting the ulnar and radial nerves, the recurrent and other nerves. He observed the pulsations of the arteries and suggested ligation and sectioning experiments. In the peritoneal cavity, the appearance of living organs and the effect of the removal of organs was pointed out. He referred to castration and removal of the spleen. Within the thorax, the pulsations of the heart and arteries were observed. Vesalius noticed the collapse of lungs when the thorax was open and the ensuing symptoms of suffocation. He realized that inflation of the lungs with a bellows inserted into the trachea would prevent the appearance of the symptoms.

He recommended the pig as an experimental animal and outlined the sequence of experiments. His book also contained the first illustration of a vivisection showing a small figure of a pig tied and supine in preparation for dissection. Vesalius also worked on dogs.

Among the anatomists who followed Vesalius, Columbus, Fallopius and the latter's pupils, Coiter and Fabricius, dissected animals as well as human cadavers and were acquainted with vivisection technic. Columbus observed the pulsating heart and demonstrated the return of blood from the lungs to the heart. Coiter studied the respiratory movements in both cold-blooded and warm-blooded animals. Few anatomists not of the Paduan tradition, however, had much to do with vivisection.

It was not till Harvey, in fact, that the technic of vivisection was intentionally applied to a clearly defined physiological problem. Harvey not only observed the dilatation and contraction of the mammalian heart and the pulsations of arteries which had been previously observed by both Galen and Vesalius, but he went further. He recognized the utility of experimental methods and planned a large series of vivisections and experiments designed one to substantiate another producing a picture of a working mechanism in animation. He observed the pulsations of the heart in birds, frogs, reptiles, insects, shrimp, fish and in bird embryos as well as in mammals. He correlated anatomical patterns with his functional conclusions. Harvey's work on the motion of the heart and blood is a continuous argument in which anatomical peculiarities, observations on living parts and experiments are adroitly and logically arranged.

Harvey felt the hardening and relaxation of the ventricles of the heart and attempted to correlate the pulse with heart movements. He ligated blood vessels and compared the spurt of arteries with the welling of cut veins. He assumed a reasonable volume for the capacity of the chambers of the heart and calculated the amount of blood flowing out of the heart per unit of time. He demonstrated the difference in blood flow from the proximal and distal ends of the cut carotid artery of a stag provided by the king for an experiment. Harvey's experiments were simple and direct, and

many of his conclusions were derived merely from direct observation of vivisected animals. Harvey's book is really a primer on animal experimentation in its relation to the circulatory system.

The novelty of the method is evidenced by the lack of appreciation shown by many anatomists and by the calumny which was directed against its author. In his disquisition to Riolan, Harvey said, "There are some, too, who say that I have a vainglorious love of vivisections, and who scoff at and deride the introduction of frogs and serpents, flies, and others of the lower animals upon the scene, as a piece of puerile levity, not even refraining from opprobrious epithets."

The discovery of the lacteal vessels of the mesentery by Aselli and the first dissection of the thoracic duct by Pecquot were made on living dogs, and Pecquot, in particular, made a number of experiments on ligation of the duct and on lymph flow.

In the 1660's, the newly formed scientific academies embraced the Baconian method and, though physical and astronomical studies predominated, physiological studies were also made. Christopher Wren, Boyle, Lower, Denys and others in France and Germany made many studies in the injections of medicines into the circulation and in the transfusion of blood. Borelli's studies on muscle and joint mechanics brought a closer relationship between the newly developed ideas on physics and mathematics of the seventeenth century and the newer physiological knowledge.

The microscope, too, had its influence on physiological advance. Leeuwenhoek experimented on the viability of microorganisms and observed blood and muscles of living animals. In using a great variety of animals, Leeuwenhoek extended the number of diverse forms used for study. In this, he and his countryman, Swammerdam, had an important effect on eighteenth century physiology.

Robert Hooke, in 1667, reëmphasized the significance of artificial respiration. In an experiment before the Royal Society, a dog was "kept alive by the reciprocal blowing up of his lungs by a bellows, and then suffered to subside, for a space of an hour or more after his thorax has been so displayed." The trachea was "cut off just below the epiglottis, and bound upon the nose of



the bellows." Furthermore, it was shown that movements of the lung were not essential, since a pair of bellows arranged to give a continuous steady blast of air kept an animal alive after escape holes had been punctured in the lung by a knife. Three years later, Boyle introduced special apparatus in the form of chambers from which air could be evacuated. He compared the effect of reduced pressure in producing death or suffocation with the effects observed in drowning. Among the variety of animals subjected to reduced air pressure in his experiments were: ducks, vipers, harmless snakes, frogs, oysters, "kitlings," crawfish, "scale fishes," insects, leeches, ants, mites, sparrows and mice.

Lymph glands, endocrine glands such as the thyroid and adrenal, and salivary glands including that of the abdomen, the pancreas, had long been recognized. Functions, however, were unknown and the anatomical studies of Stenson, Wirsung, Santorini and Wharton in demonstrating ducts for the pancreas and salivary glands gave rise to speculation as to the significance of the glands. Such speculation led de Graaf to devise probably the most complicated technical procedure yet performed on living animals. He opened the abdominal cavity of a dog, slit the upper intestine and inserted a quill into the pancreatic duct. The wound was closed and the quill led to the outside of the animal, where it drained into a bottle suspended to catch the juices. After some hours, pancreatic juice had dripped into the bottle in sufficient amount for examination. Nothing was learned from the experiment, however, beyond the demonstration that the gland actually secreted a fluid of characteristic color and taste.

Few experiments during the seventeenth century, following Harvey, were of great practical or theoretical significance. Conclusions from observations on dead animals were of more value than physiological experiments. The physiological approach at this time was more a mental viewpoint of considering structure in an animated or vital way. Experiment was a supplement to the dissecting knife and the microscope, little else.

During most of the eighteenth century, the method of animal experimentation remained of minor importance though it was

extensively used by a few men, and, in the hands of two or three, the method was advanced in a technical sense. The century was a period of systematization, classification and comprehensive theories. In physiology, Boerhaave and, more significantly, Haller rearranged the anatomical contributions of the two preceding centuries into a coördinated presentation having functional emphasis. Haller's *First Lines of Physiology* and his more complete compendium remained as standards works of physiological pedagogy till the early eighteenth century. Haller performed hundreds of vivisections, repeating the work of his predecessors and extending their observations by making many experiments on a number of animal types. His distinctive observations were predominantly on nerve and muscle.

Stephen Hales, the English cleric, who spent his leisure in experiments on plant physiology, also made the first significant contribution to knowledge of circulation since Harvey, and at the same time advanced the technic of animal experimentation. He applied principles of hydraulics and calculation to the study of the vascular mechanism. He made quantitative measurements on blood pressure, and his most quoted experiments showed a direct relationship between the blood pressure and the amount of blood in the vessels. He connected a horse's carotid artery to a long glass tube by means of an excised goose's trachea, his substitute for the rubber tubing of today, and measured the height of the blood column. Quantities of blood were withdrawn between successive measurements of blood pressure.

Hales' methods showed the advantage of quantitative measurements, and also pointed out that valuable data, such as blood pressure, could be obtained by means not directly affecting the senses. The use of the thermometer by Sanctorius and later observers for studying animal heat was another example of quantitative measurements.

Spallanzani, Réamur, Hunter and Galvani were outstanding experimenters of the later eighteenth century. Réamur trained a pet kite to swallow little perforated metal capsules filled with food. After intervals in the bird's stomach, the capsules were regurgitated and the degree of gastric digestion of food was observed. Sponges simi-

larly swallowed and regurgitated gave small samples of gastric juice for *in vitro* experiments. These experiments together with some of Swammerdam's were the most significant studies on digestion till the time of Beaumont in the nineteenth century.

Spallanzani's experiments were in the nature of a continuation of Leeuwenhoek's. He studied infusion animalcules, experimented with regeneration of parts from newts and snails and studied spermatozoa from a number of animals. In experiments on the effect of stagnant air, he used a host of forms—birds, frogs, leeches, insects, snakes of various kinds, newts, snails and earth worms. The range of forms employed demonstrated differences in the vitality of warm-blooded and cold-blooded forms. He consistently experimented and did little speculating on the basis of structure, and his adherence to experiment alone was not to be found among his contemporaries. One of the controlled variables that entered into his experiments on stagnant air was barometric pressure.

John Hunter was as ardent an experimentalist as he was collector, anatomist and surgeon. He worked with a number of forms and considerable emphasis was put on the problem of absorption. One of his experiments is illustrative of his experimental acuity. One time, he ligated the external carotid artery of a stag with the expectation of observing the effect of a deficient blood supply on the growth of antlers and their coating of velvet. After several days, the antlers were still warm, and, on autopsying the animal to see if his ligature had loosened, Hunter found that the ligature was intact and that extensive anastomoses had rerouted the blood so that the antler was completely supplied. Thus, an experiment designed to show a peculiar feature in the natural history of the deer demonstrated a principle of universal medical and surgical significance. Shortly afterward, Hunter applied the method to a patient by ligating a popliteal aneurism.

Most physiological investigators observed or experimented upon the intact animal, but a method of increasing importance was the excised preparation. Galvani with his method of stimulating muscle contraction with metals devised a physiological preparation consisting of the hind legs and sciatic

nerves of frogs. Alexander Stuart, fifty years previously, had studied muscle contractions on decapitated frogs, and, three quarters of a century before this, Swammerdam had studied the contractions of excised muscle when its nerve was irritated. He made a series of investigations to determine whether a muscle changed its volume during contraction. It was Galvani, however, to whom the nineteenth century was most indebted for the isolated muscle-nerve preparation.

Under such men as Hales, Hewson and Priestley, *in vitro* experiments had been made upon blood coagulation and the variations in coloring of blood when exposed to air and various chemicals. Wollaston used models to imitate phenomena of secretory activity.

Seventeenth and eighteenth century experimenters were on the whole direct in their approach. They reported individual experiments or protocols, and ordinarily varied subsequent repetitions in minor ways. If a number of individual records, each with slightly varied modifications, pointed in the same way, evidence was considered conclusive. The same method in animal experimentation was common till after the middle of the nineteenth century when the concept of controls and exact reduplication was developed.

Even so, the fundamentals of circulatory physiology had been established and something was known about nerve, muscle and respiratory functions. Digestion, absorption of food materials, animal heat, secretion and excretion were merely fields of speculation that were scarcely touched experimentally. Body fluids and tissues had been classified, and first attempts at chemical analysis had been made. Such analyses as those of Berzelius which appeared in the first decade of the nineteenth century were rudimentary, but they expressed a fundamental similarity as to the constituent parts and concentration of organic and inorganic materials. In experiments by Priestley, Lavoisier and William Allen, small animals were subjected for periods to air and various gases with subsequent analyses, thus correlating the ambient respiratory medium chemically with the functioning of animal respiration.

(To be continued in February JOURNAL)



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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JANUARY, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### THE JOURNAL

THIS month's JOURNAL marks the tenth anniversary of the present editor's incumbency. On assuming the editorial management, we inherited three contributed articles from our predecessor. During the past ten years THE JOURNAL has grown in size so that Volume 36, 1937, comprised over a thousand pages. The growth of THE JOURNAL and the importance with which it is held by the medical profession of the state is a healthy sign. A great many of the contributions in the way of special articles from various members of the profession show very careful study and painstaking research in the subjects on which they are written. Some of the papers are in reality monographs and if bound, would sell for the price each of our members pays for an entire year's subscription to THE JOURNAL.

The demand for space is so pressing that sometimes as much as a year has elapsed before some papers can be accommodated. THE JOURNAL, as expressed on the cover, is published by the Council of the Michigan State Medical Society and therefore the papers presented at the annual meeting have prior rights to publication. The policy of the Publication Committee, however, has been to encourage contributions of merit from members of constituent county societies which have not been presented at the annual meeting of the State Medical Society.

During all this time, ten years, the cost of THE JOURNAL per member has been \$1.50 earmarked from the annual dues. The cost of printing and publication has been defrayed largely through the advertising. With a larger JOURNAL, naturally the cost of publication has been increased and the general trend has been to advance the cost of everything connected with publication, such as printing and paper. The management is endeavoring to meet these higher costs through increase of the number of pages of advertising. The reader may help by becoming advertising-conscious. The products advertised, if in the nature of pharmaceutical agents, are those tested and approved by the Council on Pharmacy of the American Medical Association. The Publication Committee will be interested in knowing your attitude in regard to THE JOURNAL as a phase of the activities of the Council of the Society.

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### THE JOINT COMMITTEE ON HEALTH EDUCATION

"DENTAL, Personal and Social Hygiene—An Interpretation of Sex Education" is the title of a bulletin under preparation and soon to be issued by the Joint Committee. This undertaking is at the request of the State Department of Public Instruction, and like the bulletins issued last year, "The Problem Solving Approach in Health Teaching" and "Health Goals of the School Child," is a product of the Sub-Committee on Health Education for the special use of teachers.

The Joint Committee activities, its objectives, and particularly its set up within the Extension Department of the University of Michigan and yet not controlled or pre-

dominantly influenced by the University, has been attracting more and more the interest and comments from interested observers throughout the country. The special recognition by the State Department of Public Instruction which has turned to this body for help in planning for the education of school children in sex hygiene under the law passed by the last legislature, is especially gratifying. It is especially gratifying to this Society whose officers years ago saw the necessity for, and had the vision of placing *authorized* medical information before the public in an efficient way. And it must be gratifying to the University whose far seeing president, Doctor Burton, and its regents, made the vision possible.

It should perhaps be assumed that every member of the Michigan State Medical Society is familiar with the origin, the functions and the objectives of this Joint Committee on Health Education. It has been brought to our attention, however, that there are some who have not been attentive to the articles in this JOURNAL concerning this committee.

The Michigan State Medical Society was the originator of the plan and it continues to be one of the most important affiliates of the group. As a Medical Society we have a distinct responsibility; therefore, we should have large concern as to its operation. The Society's continued interest was recognized this past year when, on the resignation of President Ruthven, Dr. Burton R. Corbus of Grand Rapids was made chairman of the Joint Committee. No better selection could have been made when we consider Dr. Corbus' long service to the Michigan State Medical Society as counsellor and as chairman of the counsel.

The prime objective of the Committee, almost it might be termed a creed, is to present to the public, in an organized way, the fundamental facts of modern scientific medicine. The Committee insists that the material come from an authorized source. The channels for the dissemination of information include the newspaper article, the question and answer newspaper column, the radio, formal bulletins or monographs, and probably most important of all, the lecture bureau. It is the hope of the Committee that in a much larger degree the dissemination of information on those health matters which need the coöperation of various

interested groups, will be centered here. Why should there be such a duplication of effort?

Today, we have a number of national organizations asking the citizens of the state for funds for their support, spending a part of it, and only a part of it, in bringing literature and speakers on various health subjects into the state. Latest among these is the American Social Hygiene Association, now making a campaign for funds. These are worthy causes, but a lot of money and a lot of workers are required to do a job that certainly could be done as well, if not better, by the Joint Committee. When we suggest that it might be done better, we have in mind that health talks should be from "material that comes from an authorized source," and we have noted in many, or at least in some instances, that lay speakers speaking under the auspices of these organizations have, at times, disseminated information the accuracy of which is frequently open to question.

It would seem, then, that our Society should utilize the Joint Committee in a larger degree than it does. It would be a great saving in time and effort and money. In 1936-1937 a state wide cancer educational program was conducted through the Joint Committee most successfully. The material was provided, the general policy determined, and very generally the activity was under the direction of the Cancer Committee of the State Society. Similarly, the machinery of the Joint Committee, subject only to the allocation of a limited budget, is at the disposal of any committee of the Society desirous of presenting this type of health information to the public. No other state society has such a splendid opportunity.

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## STUDENT HEALTH SERVICE

AMONG the subjects discussed at the recent conference of secretaries of state medical societies and editors of state medical journals in Chicago was that of student health service in colleges. When the older among us were in college, the idea was extremely new or non-existent. Whenever a student became ill, he sought the services of some physician in the college town and was cared for pretty much as if he were a citizen of the place or a son of a citizen. He paid



for such services and never thought of any other plan of taking care of such an emergency.

The student health service has come to be a universal feature in schools and colleges. This has probably been brought about by the great increase in college attendance as compared with three or four decades ago. There is undoubtedly a place for this service which has come to stay. For one thing, universal physical examinations have the effect of finding physical defects and therefore, where possible, leading to their correction. In this, a student health service can be very valuable. It can also render valuable aid in the matter of insuring hygienic conditions in boarding and rooming houses, as well as in the college itself. We feel, however, that such services should be limited to a field that will be for the good of the whole student body rather than individual cases of illness, the care of which is amply provided for by the medical profession of any college town or city. Students should be taught independence in the matter of medical care as in that of providing other basic necessities of life.

The idea of examination, using the word in its generic sense, is that of passing or rejecting. Care should be exercised in the matter of rejecting candidates for higher education. We have often wondered what would have happened had Robert Louis Stevenson, Elizabeth Barrett Browning, Laennec, Trudeau, Steinmetz, and a score of others we might mention, in their late adolescence, come up for physical examination for entrance in their respective colleges. After all, the prime object of a college education is to bring out the best in the intellectually fit rather than prowess on the football field.

### ARE YOU SURE?

GEORGE E. SOKOLSKY, who contributes a weekly feature to the *Detroit Saturday Night*, comments on the cocksureness of those who have a remedy for all the alleged evils of existence. He begins by a reference to Ann Bridge's "Enchanter's Nightshade," in which one of the chief characters is made to say, "My child, playing Providence is generally a dangerous game. Sometimes one must do one's part, arrange things; but vengeance, at least, is best left to the Lord God. It is said that He

has a taste for it." This character is about to reach her hundredth birthday. Wisdom usually comes late in life. According to Sokolsky, we are living in an age of sureness at a time when it is difficult to move slowly and to let things take their course. Mr. Sokolsky's article is inspired by the efforts on the part of governments and others to put in order the economic and industrial situation in which the country finds itself today. Hamlet, in a moment of despair, gave utterance to these words:

"The world is out of joint, O cursed spite  
That I was ever born to set it right"

The so-called reformer is often a very real nuisance. To the pessimist, the world has been "out of joint" for many centuries and probably will not be restored to his liking for many centuries to come. Interference may gum up the works; it is very doubtful if it can ever accomplish anything constructive.

To use a different illustration: Man has upset the balance in nature. He has cleared the land of forests and in their place we have soil erosion and droughts alternated with disastrous floods, not to mention the extinction of certain animal species. When it may be too late we have introduced the idea of conservation, which at best is a makeshift to restore the ravishes of man.

Medicine has an ancient and honorable tradition. Long experience has taught us that there are some things which we may accept as certainties. It has taught us that altruism is a virtue. It has taught us also that improvement of one's professional capacity by painstaking study and research, research perhaps for a few and study for the great majority of us, is beyond peradventure in the interests of patients as well as ourselves. Experience has also taught us that personal relationship between the doctor and the patient is in the interest of the patient inasmuch as it places on the doctor's shoulders a responsibility to which he must rise. Of these, we are sure. Whether medicine can be practiced more satisfactorily under state subsidy and control is a much mooted question. Many feel that it cannot. They feel that change should be gradual and evolutionary rather than revolutionary. To them there is no greater menace than those who come forward with doctrinaire propos-

als for the solution of economic, social or medical problems.

O Lord: Alas,  
Deliver us from the reforming ass  
Who would take down the moon and sun,  
And light the world with gas.

#### THE PROGRAM OF THE COMMITTEE ON MENTAL HYGIENE OF THE MICHIGAN STATE MEDICAL SOCIETY

The value of an adequate mental hygiene program is receiving increasing lay and professional consideration in the State of Michigan. The social and economic implications of mental health are being more and more recognized in their proper place in our socio-economic structure.

Our educational systems are beginning to appreciate that, in addition to developing the child's intellectual potentialities by academic training, the emotional makeup of the child needs careful supervision and attention in order that he may have effective maturity when he becomes an adult. In other words, schools are becoming aware of the fact that an education is more than the memorizing of facts which are later to be regurgitated to the glory and delight of instructors. Recognition is being given to the fact that an educated person is one who is able to adjust satisfactorily to his environment. Crime and delinquency, unhappiness and social failure, adults exhibiting juvenile behavior patterns and egocentricities which react to the detriment of society are some of the many factors which deserve attention in a mental hygiene program.

The medical profession has a definite obligation to make its contribution to this program and to insure a rational and scientific approach to the problem. Your Committee recognizes that many changes may be associated with infection such as syphilis, they may be associated with exogenous and endogenous toxins, with physical trauma, with a faulty development of brain structure, with disturbed autonomic mechanisms which in turn affect personality, with endocrine imbalance, with disturbances in the interrelation between sex drives of the individual and social requirements and to that potent force which we call the emotional life of the individual. In summary, one must recognize that the body and mind is one entity which cannot be divided and, therefore, the individual and his reactions must be studied as a whole.

The subject of mental health is not one to be treated lightly nor one that can be investigated without a definite scientific approach and background. With a recognition of the importance of these problems and with the desire that this Committee's work be fundamental in nature and on the basis of a long-term program, it is the plan of the Committee to present through *THE JOURNAL* of the Michigan State Medical Society and by a limited number of addresses to medical groups an educational program designed to better orient the medical profession in the field of mental hygiene.

The Mental Hygiene Committee of the Michigan State Medical Society recommends that each County Medical Society establish a committee on mental health which may assist in developing a coöperative and intelligent approach to this problem and may aid in a program which will coördinate the activities of members of the medical societies and the various social agencies.

Subsequent articles on mental hygiene will appear in *THE JOURNAL*. Medical groups desiring speakers will kindly contact the executive office of the State Society.

#### STATE HEALTH COMMISSIONER GUDAKUNST



DR. GUDAKUNST

Dr. Don W. Gudakunst of Detroit was appointed State Health Commissioner by Governor Frank Murphy on December 21, 1937. The change becomes effective February 1, 1938.

The new Health Commissioner of Michigan was born in Paulding, Ohio, forty-three years ago, was educated in Somerville, Mass., and at the University of Michigan, where he received his B.S. and M.D. degrees. After internship at the University of Michigan Hospital, he worked with the State Health Department of New Mexico and served as Chaves County Health Officer, for three years. He then returned to Detroit and was in private practice for seven years before he accepted a full-time post with the Detroit Health Department in 1929. Dr. Gudakunst is well qualified by training and experience for the State Health Commissionership.

Dr. C. C. Slemons of Grand Rapids, State Health Commissioner for the last seven years, was praised by Governor Murphy, who said that his work has been a real contribution to Michigan. The Governor hoped that Dr. Slemons would remain with the State in some executive position.

#### The Governor's Plan

Simultaneous with the new appointment, Governor Murphy announced plans to expand the public usefulness of the Department of Health. His statement follows:

"In the development of its public health program, Michigan has enjoyed many advantages which have not been available to a large number of the other states. The State Health Department and the health departments of several of our cities have records of distinguished service. The State Medical Society has long been actively interested in public health problems. Through the Children's Fund and Kellogg Foundations, philanthropic funds have been made available and put to work in the promotion of better health. In the highly industrialized areas of the State there lies an excellent opportunity for the development of industrial hygiene programs for the improvement of the health of our wage earners.

"It is the desire and aim of this administration to merge these various advantages and to syn-



chronize the efforts of all agencies in the State concerned with public health to the end that the public may obtain the fullest possible measure of benefit from them.

"Years ago, public health work was largely, if not wholly, concerned with the prevention and control of communicable parasitic diseases. That is still one of its objectives, and here in Michigan we want the State health service to be capable of making aggressive and determined war on microbes and disease. We also want to place proper emphasis on the other objectives of a modern public health service—such as prevention of disease through periodic health examinations and early detection and correction of physical defects and chronic illness. We want to take an active interest in problems of nutrition and mental hygiene and in the social, educational, and economic factors underlying them. We recognize the necessity for coordinating the work of the public health department with the other State departments that can directly or indirectly assist in promoting public health—such as the welfare, hospital, and educational departments. In brief, we want Michigan to have a health service that is an energetic and militant agency for the conservation and improvement of the public health.

"Accordingly, I am announcing the appointment of a Committee for the Coordination of Public Health Activities. The function of this Committee will be to utilize all known means for disease prevention and health protection. It will serve (1) to arouse the interest of the community in its own health problems; (2) to secure the cooperation of all professional and educational groups, more especially the medical and dental professions; (3) to bring about a close working relationship between the official and non-official agencies—the county, city, town, state, and federal governmental forces on the one hand and tuberculosis and health societies, nursing associations, various special professional groups, etc., on the other.

"This committee will be made up of the following persons in addition to the Commissioner of Health:

Dr. John Sundwall, Director of the Division of Hygiene and Public Health of the University of Michigan;

Dr. Bernard Cary, Medical Director, Children's Fund of Michigan, Detroit;

Dr. Mathew Kinde, Medical Director, W. K. Kellogg Foundation, Battle Creek;

Dr. Ledru O. Geib, Chairman of the Preventive Medicine Committee of the Michigan State Medical Society, Detroit;

Dr. P. C. Lowery, Detroit.

#### Creation of Inter-Department Committee

"In addition to the Coordinating Committee, there is created a committee representing the State departments whose programs have a strong public health content. Through the functioning of this inter-departmental committee, it is hoped that the foundation will be laid for progress along important lines; that friction and duplication of efforts will be avoided; that economies will be effected; and that neglected and poorly cared for groups will be brought into the picture according to their needs.

"The following persons will serve on this committee together with the Commissioner of Health: the Director of Welfare, Director of the State Hospital Commission, Superintendent of Public Instruction, Commissioner of Agriculture, and the Commissioner of Labor.

#### Survey of Health Needs

"As an additional aid to the State Department of Health, it is desirable that immediate steps be taken to have a complete survey made of the health needs of the State and the existing facilities for meeting these needs. The Governor and the Commissioner of Health have joined in a request to the American Public Health Association to furnish such a survey. The American Public Health Association is at the present time in a position to grant such a request, adequate funds having been made available to carry on such studies in selected states. It is reasonably certain that such a request can be granted if evidence is advanced showing that a planned, coordinated program is being developed in the State of Michigan.

"At this time, also, I wish to announce the appointment to membership on the State Advisory Council of Health of Dr. H. Lee Simpson, of Detroit, and Dr. E. S. Thornton, of Muskegon."

## GOLFERS' SPECIAL TO 'FRISCO

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# President's Page

## OUR PLACEMENT SERVICE

**S**ERVICE to the people is the foundation of our private medical practice. Personal service to the patient typifies the art of America's system of medicine—an understanding, confidential, human relationship too precious to be sacrificed.

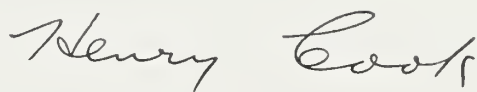
The distribution of this service to all who need it is the responsibility of the medical profession. The State of Michigan, unique in its geography, type of population, rural and urban areas, etc., presents an unusual problem. The question has been given exhaustive study by the Michigan State Medical Society, which fully recognizes the complexity of the situation. In an unostentatious way, the medical profession of the State has for years been developing workable programs for better and more complete distribution so that people in all groups may receive good medical service when they need it and at a price they can afford to pay.

The latest step in this direction is the creation by the Michigan State Medical Society of a "Placement Service." This is a dual program designed to help any community which may feel the need of a doctor of medicine, and also to assist young physicians about to enter practice, or older doctors, to find good locations.

A survey of the entire eighty-three counties of Michigan is now being made to ascertain the need for any additional medical service anywhere in the state. A permanent spot-map in our Executive Office in Lansing will indicate where doctors may be needed. Full information, statistics and documents will complete the picture for applicants. The Michigan State Medical Society will use its influence to place qualified physicians where opportunities arise, to insure that needed medical service is supplied to all persons in all parts of this state.

I invite and urge all members to lend full support and active co-operation to the State Society's latest effort for greater distribution of medical care.

Respectfully submitted,



President, Michigan State Medical Society.





## TRAIN YOUR OFFICE STAFF

By ALLISON E. SKAGGS and HENRY C. BLACK

WHETHER your office staff consists of only a receptionist or involves nurses, laboratory technicians and stenographers, careful training of these people will not only be of material help to them in holding their jobs, but also to you in obtaining better assistance, better collections and a more smoothly running office. There are many offices throughout the state where it is a pleasure to watch the courteous and friendly finesse with which patients are handled. All comers are greeted in a friendly and obliging manner, and many are called by name. The telephone is answered promptly with a cheery "This is Dr. Blank's office," and the whole office seems to radiate courtesy, friendliness and efficiency. Many of these girls who do such a fine job were never trained at all, but developed their abilities with a native intelligence that results in excellent service. In direct contrast is the assistant whose abrupt manner gives the impression that she is conferring a favor upon all who telephone or come into the office. Happily these assistants are not found often.

Patients coming into a doctor's office are often ill and uncomfortable, and should be greeted by someone immediately, rather than be allowed to sit in the waiting room and wonder whether the doctor is in and how long it will be before their turn. Some stop in just to leave word for the doctor or to pay an account and such patients certainly should not be kept waiting. Occasionally, a doctor has to leave on an emergency, and when this is the case patients in the waiting room should be informed of the situation with a proper explanation. If this is done, patients, who might otherwise go out saying, "The doctor is too hard to see, he doesn't tend to his business," will go out instead remarking, "How busy Dr. Blank is! What a fine doctor he must be!"

Some of a doctor's success in getting and holding his patients depends upon the manner in which the telephone is answered. There have been cases where a patient call-

ing for the doctor is merely told "The Doctor is not in," whereupon he hangs up and may or may not ever call again. How much better to have said, "Dr. Blank is out right now but I think I can reach him. Is it anything urgent?" A continuation of the conversation very likely would arrange for an appointment, or at least a satisfied feeling on the part of the patient, even though it was necessary to wait some time for the doctor.

In addition to patients there are many other callers in a doctor's office, including detail men and salesmen of all kinds. The intelligent office assistant will always find out the purpose of the call, and it is easy to instruct her as to which ones you always want to see, which ones to ask to wait, and which ones to eliminate. Many equipment, instrument and drug salesmen of reputable houses should be seen frequently, as their ideas and information are valuable. It is a courtesy to any salesman for the office girl to find out whether or not the doctor wants to see him, and about how long he will have to wait. In the same manner, she can save a lot of the doctor's time by not allowing him to be bothered by salesmen and solicitors whom he does not want to see at that time.

Study your own office as to the possibility of making more use of your office staff. Would a buzzer save you time and steps? Does your office girl always answer the telephone during office hours, find out who is calling and determine whether or not you can conveniently come to the telephone? Is it possible to have her open your mail, classify it and call your attention to particularly important correspondence? Does she write all your receipts, keep all of your records up to date, and balance all of your cash? Does she have case record information on your desk when the patient comes in? Does she keep all of your correspondence, reports, and accounts so that they may be easily located? Are the letters she sends out neat and grammatically correct? In other words, do you use her to the extent of her capabilities? On the other hand, do you allow her a full

*(Continued on page 101)*

# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## THE ANNUAL CONFERENCE OF COUNTY SECRETARIES

THE Executive Committee of the Council has approved the date of Sunday, January 23, for the Annual Conference of County Secretaries. With the call of this meeting comes the responsibility of each of the fifty-four county secretaries to be present. This session is provided by the State Society at considerable cost of time and funds in order that each component society, through personal contact with its secretary, may be conversant with many of the plans and problems of organized medicine in Michigan.

The program for the conference will include concise presentations of such subjects as: Press Relations; Membership Plans; The Afflicted Child Law and Its Operation; What the American Medical Association is doing; Public Relations, and a panel discussion on Preventive Medicine, including Cancer, Syphilis, Tuberculosis, Mental Hygiene, Maternal and Child Welfare and Immunizations.

The County Secretary is the Key-man of his County Society and as such should accept the obligation of representing his organization at this Annual Conference. The President and other officers of County Societies should, if at all possible, accompany their Secretary to this meeting.

Dr. Secretary, mark the date, *January 23*, on your calendar and plan now to attend the *Secretaries' Conference* at the Olds Hotel, Lansing, from 10:00 A. M. to 4:00 P. M.

## THE FILTER SYSTEM

THE Michigan State Medical Society recently conducted a survey of the eighty-three counties in Michigan to determine the status of the Filter System, with special reference to the operation of the Afflicted Child Act.

A digest of the Survey has been submitted to the Auditor-General of the state. It should prove of considerable value in analyzing the case-load of Afflicted Child Cases.

The Survey has reaffirmed the contention that well-functioning Economic and Medical Filters enhance the operation of the Afflicted Child Act to the end that worthy patients receive proper care and that those not entitled to State Aid are returned to their physicians as private patients. Un-

hampered and conscientiously operated filters will conserve the State funds for deserving children and thereby prevent a premature depletion of such funds, and incidentally compel all other patients to assume their own obligations.

While in a few counties the Medical profession has not actively operated the Medical Filter, nevertheless most of the inefficiency has occurred in the Economic Filters where a lack of proper investigation has been responsible for an increased case-load of undeserving patients.

It was most gratifying to learn that the Filter System was operating, or was at least set up for operation, in eighty of the eighty-three counties of Michigan.

## THE PRACTICE OF MEDICINE IN HOSPITALS

THE principles that should be followed in hospital organizations have been promulgated by the Council on Medical Education and Hospitals of the American Medical Association. These have to do with all phases of hospital operation and administration. While adherence to any set of rules is not mandatory it behooves the Medical profession to consider closely those principles applying especially to staff organization.



The accrediting of a modern hospital by such bodies as the American Medical Association and the American College of Surgeons is contingent upon proper staff qualifications. From the "Essentials of a Registered Hospital" we note the following:

"Staff membership and the use of the hospital's facilities must be limited to doctors in medicine. Where cult practitioners, osteopaths, chiropractors or other healers outside the scope of regular medicine are allowed to use the hospital's diagnostic facilities, to prescribe for or treat patients in the hospital, or to enter orders or other data on the case records, such a hospital obviously cannot be recognized or endorsed by the American Medical Association."

It is obviously apparent that unless staff membership is limited to Doctors of Medicine, the services of internes and other desirable features would be denied in such institutions. With the loss of support and coöperation of the Doctors of Medicine in any community, a hospital would promptly lose approval of the Michigan Crippled Children's Commission and would, therefore, be denied the opportunity to receive state cases, such as Afflicted Children.

In a recent mandamus case in Michigan where two osteopaths sought the privilege of practicing in a municipally operated hospital, the Court ruled that osteopaths are not permitted to practice in the city, county, state or other public hospitals where the Board has made reasonable rules limiting admission to Doctors of Medicine.

The Medical profession should review carefully the rules and regulations of the hospitals in their communities and make certain that the well-being and health of their citizens are protected and enhanced by proper staff requirements, that is—limitation of membership to Doctors of Medicine.

All hospitals should be definitely certain that their rules and regulations are reasonable as far as they relate to the practice of medicine and surgery in those hospitals. Hospital Boards of Control should immediately see to it that they are reasonable and that there has been no unwarranted delegation of their authority.

The "Essentials of a Registered Hospital," prepared by the Council on Medical Education and Hospitals of the American Medical Association, are as follows:

Hospitals seeking admission to the register should have the following qualifications:

1. *Organization.*—The organization should consist

of a board of trustees or other supreme governing body having final authority and responsibility and an executive officer or superintendent to carry out the policies adopted by the governing body. The executive officer should be assisted by adequate competent personnel.

Regardless of the form of organization, the hospital should function primarily in the interests of the sick and injured of the community.

2. *Staff.*—This constitutes the most important essential. The staff should be organized and composed of regular physicians who are properly qualified as to training, licensure and ethical standing.

*Staff membership and the use of the hospital's facilities must be limited to doctors in medicine. Where cult practitioners, osteopaths, chiropractors or other healers outside the scope of regular medicine are allowed to use the hospital's diagnostic facilities, to prescribe for or treat patients in the hospital, or to enter orders or other data on the case records, such a hospital obviously cannot be recognized or endorsed by the American Medical Association.*

Regular staff conferences should be held at least monthly and preferably more often. All deaths that occur during the period intervening between meetings, perplexing cases, and patients who do not respond to treatment should be discussed. When postmortem examinations have been performed there should be a presentation of the clinical aspect of the patient and the postmortem observations. Interesting pathological specimens from surgery or removed at postmortem should be presented and discussed with regard to the preoperative or ante-mortem findings.

Minutes of staff conferences should be kept and filed with the hospital records. The activity of the staff as to scientific meetings and clinical and pathologic conferences is an index to the scientific mindedness and progressiveness of the group.

3. *Nurses.*—A competent nursing staff should be provided by employing an adequate number of registered nurses who are graduates of schools of nursing recognized by the state board of nurse examiners, or by maintaining such a school.

All nursing should be supervised by qualified registered graduates.

4. *Records.*—An adequate record system should be maintained. No particular system or set of forms is recommended, since requirements are not the same under varying circumstances. The average case record should include at least a brief medical history, physical examination, laboratory reports, diagnosis, operative record, progress notes, nurses' notes and summary. Case records should be complete in every department and reviewed and signed by the attending physicians before they are placed in the permanent file. Roentgenologic interpretations, pathologic descriptions and diagnoses of tissues removed in the operating room, and (when an autopsy has been performed) a description of postmortem observations, should be included with the patient's record.

Case histories and physical examinations should be recorded in the patient's chart within twenty-four hours after the patient has been admitted to the hospital. A patient should not be operated on, except in the case of emergency, when the history, physical examination and routine laboratory work have not been completely recorded in the chart. The duty of recording these data falls on the attending physician and he should be held directly responsible for the case records.

Monthly and annual analyses of hospital service should be made in order that the staff may be in a position to improve its service.

5. *Pharmacy*.—The handling of drugs should be adequately supervised and should comply with state laws.

6. *Pathology*.—All tissues removed in the operating room should be examined, described and diagnosed by a competent pathologist excepting tissues, such as tonsils and teeth, in which the pathologic changes are quite obvious.

A physician-pathologist should be employed on a full time or part time basis. When this is not practicable, arrangements should be made with a consulting pathologist for tissue diagnosis, postmortem work and the interpretation of the more complicated tests and determinations in clinical and surgical pathology, as well as in general clinical laboratory work. The pathologist preferably should be one listed by the Council on Medical Education and Hospitals of the American Medical Association. The Council's list of physicians specializing in clinical pathology or pathology is available on application.

*Autopsies*.—Every effort should be made to secure consent for autopsies, which should be performed by a pathologist or the best qualified other physician available.

7. *Radiology*.—The hospital should provide or have ready access to radiologic equipment and service. When a full time or part time physician-roentgenologist cannot be employed, the services of such a consultant should be secured. Radiologic interpretations must be made only by a competent roentgenologist. A description of the roentgenologic examinations should be placed in the patient's chart. The physician-roentgenologist preferably should be one who is a diplomate of the American Board of Radiology or a physician whose qualifications are acceptable to the Council on Medical Education and Hospitals of the American Medical Association.

A list of physicians specializing in radiology and roentgenology is available on application.

8. *Ethics*.—In order that a hospital may be eligible for registration it will, of course, be expected that the staff and management conform to the principles of medical ethics of the American Medical Association with regard to advertising, commissions, division of fees, secret remedies, extravagant claims, over-commercialization and in all other respects.

## Executive Committee of the Council

November 10, 1937, and December 12, 1937

### HIGHLIGHTS:

1. "Placement Service" created, to aid localities in need of a doctor of medicine, to aid physicians in their search for a good location.
2. Occupational Disease Law discussed with the Commissioners of the Department of Labor and Industry.
3. Medical care of old age pensioners and others on relief discussed with the Welfare Director.
4. Recommendation made that medical and surgical care, under the Afflicted Child Law, be available only to the truly indigent.
5. Study of Rehabilitation of E.R.A. cases instituted.
6. Syphilis Control Program of Ingham County Medical Society approved.
7. Statement on "Committee of Physicians."
8. Coöperation offered the Michigan Child Guidance Institute.
9. "Benevolent Fund" referred for study to the Advisory Committee, Woman's Auxiliary.
10. Membership plans for 1938 approved.

### Meeting of November 10

1. *Roll Call*.—The meeting was called to order in the Olds Hotel, Lansing, at 1:10 p. m., by Chairman P. R. Urmston. Present were: Drs. Urmston, A. S. Brunk, H. R. Carstens, I. W. Greene, V. M. Moore and P. A. Riley. Also present: Drs. Henry Cook, L. Fernald Foster, J. H. Dempster, Paul A. Klebba, H. A. Luce, T. F. Heavenrich, B. R. Corbus, C. D. Hart, T. K. Gruber, and Executive Secretary Wm. J. Burns.

2. *Minutes*.—The minutes of the meeting of October 17 were read and approved.

3. *Department of Labor and Industry*.—The commissioners of the Department of Labor and Industry were present to discuss the medical phases of the Occupational Disease Law: Commissioners Bess Garner, John Cassin, Walter Kirkby, Lionel Heap and George Krogstad; also Theodore Ryan and James Hill of the Department. The O.D. law generally was discussed, and specifically section 6 relative to the appointment of medical commissions in controversial cases (whether a person has or has not a specific disease).

The Chairman, Dr. Urmston, stated that the medical profession would be very happy to coöperate with the Department of Labor and Industry, and the Labor Commissioners stated they would depend upon the M.S.M.S. for help and guidance in the medical features of the Occupational Disease Law. The Commissioners thereupon excused themselves from the meeting.

The Secretary was requested to send a letter to the president and secretary of each component county medical society of Michigan, explaining this matter, sending a copy of the O.D. act, and outlining what is expected of the physicians and the Medical Commissions.

4. *Financial Report*.—The financial report for the month of October, 1937, was presented. The Treasurer presented the report on the bonds. Bills payable were presented and ordered paid, on motion of Drs. Brunk-Riley.

5. *Afflicted Child Law*.—Messrs. C. D. Hill and E. O. Edmunson of the Auditor General's Office were present re the Afflicted Child Law problems, the Filter System, and recommendations for the



gradual establishment by all county medical societies of a "Medical Director" to act as a liaison between physicians and the Auditor General's Office.

Secretary Foster presented a report on the Filter System from eighty of the eighty-three counties.

The following motion was offered by Drs. Moore-Carstens; that, in order that adequate medical and surgical service be made available to the truly indigent, the Executive Committee of The Council, Michigan State Medical Society, formally approve any action by Auditor General Gundry in restricting payment of bills under the Afflicted Child Law to those cases which are economically unable to pay. The motion was thoroughly discussed, and carried.

Reasons for this motion: (a) At the present rate, after approximately eleven months, the entire allocation will be exhausted, and physicians again may be requested to perform Crippled and Afflicted cases for \$1.00 per case. (b) Many of these cases should be private cases and the present *laissez-faire* attitude may lead to more State Medicine.

6. *Welfare Medical Care.*—(a) Old Age Pension. Mr. James Bryant, of the State Welfare Commission, discussed the new state welfare laws; the referendum will hold in abeyance the operation of these laws until November 8, 1938. The effect of the referendum on the present program: (a) The Attorney General ruled it does not tie up the appropriation; (b) Under the Social Security Act, activities can be carried on as at present.

(b) *Medical Care to Old Age Pensioners.* The County Unit plan was set up under the new law, which, however, is held in abeyance by the referendum. The Old Age Pension Bureau cannot appropriate money to the E.R.A. for this medical care. While \$30.00 is the maximum allowed to a person, the average per person in the state is now \$18.52. Nothing can be done at the present time re medical care to the old age group unless the Social Security Board arranges something. The survey of old age pensioners and the cost of medical care in Oakland County was discussed.

(c) *Rehabilitation Program.* The West Virginia Plan was discussed. Mr. Bryant stated that at the present time there are 2,000 hernias in Michigan, many of whom could, if operated upon at this time, obtain gainful employment and be taken off the Welfare rolls.

Under the new welfare laws, these preventive measures would be allowed. Mr. Bryant felt it could be started, even under the present laws, in a small way and if successful, be made a state project. The situation should be given immediate study. Mr. Bryant and the Executive Committee will get together at a later date, as Mr. Bryant stated he would work up a definite project. Such a rehabilitation service would require the coöperation of the relief agencies, the employers, and the medical profession. Mr. Bryant was thanked for his attendance and information.

7. *Examination of Barbers.*—Commissioner of Health C. C. Slemons presented the problem of the amendment to the Barbers' Law (Public Act No. 30 of 1937) which stated as part of the student qualifications: "Any person is qualified to receive a certificate of registration as a registered student who has a certificate from the Department of Health of the State of Michigan certifying that he or she is free from contagious and infectious disease." Dr. Slemons stated this would apply to several hundred persons a year, and that he wished to deputize all physicians to do these examinations. The secretary was instructed to place this item in the Secretary's Letter and in THE JOURNAL, and urge the secretaries of the county medical societies in which

barber colleges are located (Grand Rapids, Detroit, Flint and Marquette) to bring this information to the attention of all physicians of their county medical societies.

Dr. Slemons stated that in the first five hundred examinations under the new Prenuptial Physical Examination Law, nine positive cases of syphilis were uncovered.

8. *Basic Science Board.*—President Cook presented the request of the Governor for the nomination of teachers to the Basic Science Board, in compliance with the law. The Executive Committee approved the names of W. O. Nelson, Wayne University; and H. J. Stafseth, Michigan State College.

9. *Syphilis Control Plan of Ingham County Medical Society.*—This was explained in full by Dr. Robert S. Breakey of Lansing. The plan has the approval of U. S. Surgeon General Thomas Parran, Jr., and Michigan State Health Commissioner C. C. Slemons. President Cook suggested that the Ingham County Medical Society and other county medical societies should be encouraged to carry on this type of work. Motion of Drs. Carstens-Moore that the Executive Committee of The Council of the M.S.M.S. thank Dr. Breakey for his presentation of the Syphilis Control Program of the Ingham County Medical Society and expresses its warm commendation, interest and encouragement for this unique program, that it be urged to develop this work to cover all possible phases. Motion carried unanimously.

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#### *Joint Meeting of Executive Committee of the Council with the Legislative Committee*

10. *Roll Call.*—All above-mentioned members of the Executive Committee were present. Members of the Legislative Committee present were: Drs. L. G. Christian, chairman; H. A. Luce, P. R. Urnston, J. B. Bradley, O. D. Stryker. Also present: W. A. Hyland, C. C. Slemons and Attorney Earl W. Munshaw. Absent: Drs. Wm. H. Honor, G. L. McClellan and A. R. Miller.

11. *Hospital Practice.*—Senator Munshaw read extract of his brief on the practice of medicine in hospitals and presented recommendations.

The recommendations, as well as the judicial precedents, were discussed generally by the members of the Executive Committee and the Legislative Committee.

Senator Munshaw was thanked for his information; Dr. Slemons was thanked for his attendance and advice.

12. *"Committee of Physicians."*—The publicity of the "Committee of Physicians," and the reply of Dr. Henry Cook, were read. Motion of Drs. Carstens-Moore that the Secretary of the "Committee of Physicians" be written to the effect that the letter from President Henry Cook dated October 30, 1937, fully explains the position of the Executive Committee of The Council of the M.S.M.S.; that a copy of President Cook's letter be sent to Dr. Olin West, Secretary of the A.M.A. Carried unanimously.

Motion of Drs. Carstens-Moore that the President and Secretary be requested to prepare a statement covering this matter for transmittal to the component county medical societies, and for publication in THE JOURNAL. Carried unanimously.

13. *Membership Committee Plans.*—The plans of Dr. M. H. Hoffmann, Chairman of the M.S.M.S. Membership Committee, were presented. Motion of Drs. Carstens-Brunk that the Executive Committee of The Council approve the plans of the Membership Committee, and that it request the Chairman to present his necessary budget for 1938, together



with any additions to his plans. Carried unanimously.

14. *Nurses Training Schools*.—Dr. Cook reported on the meeting with the nurses in Detroit on November 3. Motion of Drs. Carstens-Brunk that President Cook be thanked for his report and be authorized to appoint a committee up to three members to meet with similar committees from the nursing organizations at a session to be held in Lansing on November 17. Carried unanimously. (Dr. Cook appointed Drs. Arnold, Oakes and Marshall.)

15. *Referrals from State Sanatoria*.—Dr. Foster reported on this matter, stating that a list was being prepared for presentation to all interested parties.

16. *Annual Meeting Plans*.—Report was given by Dr. Foster on the facilities of the various Detroit hotels. Motion of Drs. Brunk-Greene that the Book-Cadillac Hotel be selected as the headquarters for the 1938 Annual Meeting. Carried unanimously.

Motion of Drs. Greene-Brunk that the Committee on Scientific Work for the 1938 Annual Meeting of the M.S.M.S. consist of the Secretary of the M.S. M.S., plus the chairmen and secretaries of the seven Sections. Carried unanimously.

17. *Hospital Forms*.—The sample form to be signed by patients, as suggested by Dr. Ralph G. Cook of Kalamazoo, was read. The Executive Committee felt that each hospital, due to peculiar local conditions, should have its own form, properly approved by its attorneys; that the proposed form does not conflict with any regulations about which it has knowledge, but it should be checked for its legality. It would not apply to certain rules of the Auditor General's Office plus the Michigan Crippled Children Commission re afflicted and crippled child cases.

18. *Adjournment*.—The meeting was adjourned at 11:45 p. m.

## Meeting of December 12

1. *Roll Call*.—The meeting was called to order by Chairman P. R. Urmston at the Book-Cadillac Hotel, Detroit, at 3:05 p. m., with all members present. Also Drs. Henry Cook, L. Fernald Foster, Henry A. Luce, James H. Dempster, R. H. Pino, H. B. Fenech, Wm. J. Stapleton, Jr., George A. Netschke of the Book-Cadillac, and Executive Secretary Wm. J. Burns.

2. *Minutes*.—The minutes of the meeting of November 10, were presented, corrected in two items, and approved as corrected on motion of Drs. Carstens-Brunk.

3. *1938 Annual Meeting*.—Mr. George A. Netschke of the Book-Cadillac Hotel outlined the facilities and services which the Book-Cadillac Hotel offers the M.S.M.S. for its 1938 convention. All items were discussed, and Mr. Netschke was thanked for his explanations, and withdrew.

4. *Financial Report*.—This was presented. Bills payable for the month were presented, and ordered paid on motion of Drs. Carstens-Greene. A Financial Report on the JOURNAL for the years 1935, 1936 and ten months of 1937 was presented by the Executive Secretary. Mr. Burns' report is to be presented to each member of the Publications Committee, which shall study same and present report and recommendations at the Mid-Winter Meeting of The Council.

5. *Occupational Diseases*.—A report from the Advisory Committee on Occupational Diseases was read by Secretary Foster; also extract re Occupational Diseases and Medical Commissions as published in Secretary's Letter of December 1. The

matter of checking important parts of the Krogstad conference on Occupational Diseases, picking out the best papers and ascertaining the cost of reprinting same, for the medical profession, was referred to the Advisory Committee on Occupational Disease. Motion of Drs. Carstens-Brunk that the report of the committee be accepted and the committee be requested to continue its studies in order to disseminate necessary information to the membership. Carried unanimously.

6. *Filter System*.—Dr. H. B. Fenech, member of the Crippled Children Commission, presented the problem of severe burns to afflicted children. This was thoroughly discussed and a probable solution adopted. The Executive Committee expressed thanks to the Commission for bringing this problem to its attention.

Commissioner Fenech also brought up the question as to whether all cases of osteomyelitis should be considered as orthopedic cases; also the matter of hospital investigation, in afflicted child cases; that a new fee schedule would be promulgated as of March 1; a resumé of the work of the coordinator in Wayne County. The Executive Committee thanked Commissioner Fenech for his attendance and information.

7. *M.S.M.S. Postgraduate Fund*.—Report of Committee working with Dr. J. D. Bruce on the p.g. fund was presented by Drs. Cook, Foster, and Urmston. Another meeting with the Postgraduate Medical Education Committee will be held in January.

8. *Committee on Distribution of Medical Care*.—Chairman Pino presented report on meeting of December 8. He referred to telegram sent to Secretary Olin West of the A.M.A. re medical care to old age pensioners, and telephone answer of Dr. West. Dr. Pino presented statistics on the Afflicted Child cases in Wayne County and the recent drop in commitments, saving between \$15,000 to \$20,000 in Wayne County alone. Dr. Pino was thanked for his report and information.

9. *Mental Hygiene Committee*.—The report of meeting of November 11 was presented by Chairman Luce, and thoroughly discussed. Motion of Drs. Carstens-Greene that the Executive Committee accept and approve the report of the Mental Hygiene Committee, and authorize Chairman Luce to place before the Postgraduate Medical Education Committee at its meeting of December 16, the request that more mental hygiene subjects be placed on the Postgraduate courses. Carried unanimously.

The Executive Committee discussed the postgraduate work for 1938. Motion of Drs. Moore-Brunk that the Councilors be asked to be prepared to present suggestions at the Mid-winter Meeting of the Council as to how to improve the postgraduate conferences next year. Chairman Urmston was authorized to write such a letter to the councilors, and was also delegated to discuss all points aimed for better coordination, with the Postgraduate Education Committee. Carried unanimously.

10. *Medico-Legal Committee*.—The monthly report of the committee was presented by Dr. Stapleton. The report was accepted and placed on file.

11. *Preventive Medicine Committee*.—The reports of the Preventive Medicine Committee, plus the Advisory Committee on Syphilis Control and the Advisory Committee on T.B. Control were presented and thoroughly discussed. Motion of Drs. Carstens-Greene that the report of the Preventive Medicine Committee and the Advisory Committee on Syphilis Control be accepted, and that Chairman Geib be requested to present further details re postgraduate courses to the Council at its Mid-winter Meeting in January.



The request of the Preventive Medicine Committee and other committees for one-half day and an evening on the Annual Meeting program next September, devoted to preventive medicine subjects, was referred to the Committee on Scientific Program. Motion of Dr. Greene, seconded by several, that the Executive Committee feels that the Committee on Scientific Work should accept the suggestions as made by the Preventive Medicine Committee et al, for the ballot to be sent to the membership. Carried unanimously.

Re the reports of the Advisory Committee on Tuberculosis Control: motion of Drs. Greene-Brunk that the reports be accepted and approved. Carried unanimously.

Motion of Drs. Moore-Brunk that the Advisory Committee on T.B. Control and the Michigan Association of Roentgenologists take up the matter of x-ray work done by the Michigan Tuberculosis Association at an early meeting, and refer its recommendations to the Council at its Mid-winter Meeting in January, 1938. Carried unanimously.

12. *Advisory Committee to Woman's Auxiliary.*—Report of meeting of November 17 was presented. The question of the creation of a Benevolent Fund, as asked by Chairman Collisi, was discussed. Motion of Drs. Carstens-Greene that the Executive Committee of The Council approve such a worthy project, and feels it should be given further study with details being referred back to the Council or its Executive Committee at a later date. That the Advisory Committee to the Woman's Auxiliary should contact those states (Pennsylvania and Massachusetts) having such Funds in existence at the present time, for full information. Carried unanimously.

13. *Cancer Committee.*—The report of the Cancer Committee (meeting of September 28) was presented, discussed, and on motion of Drs. Carstens-Moore was accepted. Carried unanimously.

14. *Michigan State Board of Registration in Medicine.*—The Executive Secretary reported on meeting between Dr. J. E. McIntyre, Dr. C. C. Slemons, and Mr. Burns in Lansing on Friday, December 10, re use of State Department investigator, and the drawing up of a questionnaire.

15. *Joint Committee Funds.*—A letter from the Joint Committee re transfer of funds to the U. of M. was read. Motion of Drs. Greene-Moore that the funds remaining in the hands of the M.S.M.S. and belonging to the Joint Committee on Health Education, be transferred to the Committee. Carried unanimously.

16. *Placement Service.*—The Executive Committee discussed further the creation of a Placement Service and on motion of Drs. Brunk-Carstens, authorized the creation of this service, to be placed in the hands of the secretary. Carried unanimously.

17. *Wassermann-Fast Case.*—The Chair referred to the Advisory Committee on Syphilis Control the matter of answering the question of many physicians: "What is a Wassermann-fast case?"

18. *Iodized Salt Committee.*—The request that the Iodized Salt Committee be continued for 1938, was read by Dr. Foster. Motion of Drs. Brunk-Greene that the Executive Committee suggest to President Cook that this committee be re-appointed. Carried unanimously.

President Cook re-appointed the committee for 1937-38.

19. *County Secretaries Conference.*—Motion of Dr. Greene, seconded by several, that the matter of

holding the County Secretaries Conference on Sunday, January 23, 1938, in Lansing, be approved. Carried unanimously.

20. *Michigan Child Guidance Institute.*—This matter was discussed by Dr. Luce, in detail. Motion of Dr. Greene, seconded by several, that the Executive Committee approve the suggestions and the report of the activities of the Child Guidance Institute as presented, and recommend to it that it utilize the services of the Michigan State Medical Society and especially of its Public Relations Committee for dissemination of its projects to physicians throughout the State. Carried unanimously.

21. *American Social Hygiene Association.*—The activities of this organization were discussed. Motion of Dr. Greene, seconded by several, that the Michigan State Medical Society is sympathetic to all legitimate efforts toward the eradication of syphilis, and that organizations having this purpose be invited to work with and through the Michigan State Medical Society. Carried unanimously.

22. *Adjournment.*—The meeting was adjourned at 11:15 p. m., the Chair thanking all for their attendance, help and advice.

## COUNCIL AND COMMITTEE MEETINGS

1. Friday, November 26, 1937—Advisory Committee on Tuberculosis Control—Olds Tower, Lansing—2:00 p. m.
2. Friday, November 26, 1937—Cancer Committee—Woman's League, Ann Arbor—6:00 p. m.
3. Sunday, December 12, 1937—Maternal Health Committee—Hotel Olds, Lansing—12 noon.
4. Sunday, December 12, 1937—Advisory Committee to the Parole Commission—Book-Cadillac Hotel, Detroit—3:00 p. m.
5. Sunday, December 12, 1937—Executive Committee of The Council—Book-Cadillac Hotel, Detroit—3:00 p. m.
6. Thursday, December 16, 1937—Committee on Postgraduate Medical Education—W.C.M.S. Building, Detroit—6:00 p. m.
7. Wednesday, December 22, 1937—Cancer Committee—Woman's League, Ann Arbor—6:00 p. m.
8. Wednesday and Thursday, January 12 and 13, 1938—Midwinter Meeting of The Council—Hotel Statler, Detroit—10:00 a. m.

## COUNTY SECRETARIES CONFERENCE

Lansing, January 23, 1938

Hotel Olds, 10:00 A. M. to 4:00 P. M.

Secretaries, Presidents, other officers  
and members of county medical  
societies are cordially invited.

## COUNTY SOCIETIES

### BERRIEN COUNTY

A. F. BLIESMER, M.D.  
*Secretary*

The November meeting was called to order by President C. S. Emery at Niles on November 17, 1937.

The credentials committee approved the application of Dr. Leonard Weil to membership. It was moved by Drs. Reagen-Kok that Dr. Weil be admitted to membership. Passed. The application to membership of Dr. Ida Harper of Benton Harbor was read and presented to the credentials committee.

The nominating committee reported and presented the following in nomination for 1938:

President—Dr. Clarence Gillette.  
Vice President—Dr. J. W. Gunn.  
Secretary—Dr. A. F. Bliesmer.  
Delegate—Dr. W. C. Ellet.  
Alternate—Dr. Fred Henderson.

In the report of the Filter Committee, members were requested to turn down cases that were considered unnecessary or borderline regardless of the referring agent, because of dwindling funds. Also that doctors presenting bills for emergency cases be asked to appear before the filter board to briefly outline their case and findings following operation or emergency care.

The question of the proper handling of requests by various organizations for free health or physical examinations was brought up. In the past there have been no rules governing this and no committee organized to hear and act on such requests. After considerable discussion a committee composed of Drs. Ellet-Hart-Richmond was appointed to consider this problem and to make recommendations at the next regular meeting.

The speaker of the evening, Dr. Gordon B. Myers of Detroit, was introduced by Dr. Bliesmer. He spoke on "Sulphanilimide."

### CALHOUN COUNTY

WILFRID HAUGHEY, M.D.  
*Secretary*

The November meeting of the Calhoun County Medical Society was held at the Parker Hotel, Albion, Tuesday evening, November 2, 1937. Past-President Carl G. Wencke presided.

Dr. O. Johnson, of Marshall, reported for the Special Committee on group health and accident insurance that the proposed plan was legal, seemed to "cover" as well as claimed and was noncancelable as to individual policy as long as the master policy is in force. The committee requests that their report be accepted and the committee discharged. H. M. Lowe-Melges so moved, and the motion carried.

Dr. Harvey Hansen, for the special committee on malpractice insurance, reported that his committee had contacted two companies. It asks to have its report accepted and to be discharged. By motion of Cooper-Kolvoord the petition was granted.

The secretary read a communication from the Merchants Credit Bureau regarding a credit and

rating set-up. They have interviewed President Brainard, the secretary, and several others, and have an attractive plan. In the absence of Dr. Brainard, who has especially studied this plan, it was suggested that Dr. Brainard appoint a committee to investigate and report soon.

A communication was read from the Michigan Department of Health regarding tests and examinations for marriage licenses under the new law.

A State Society letter was read asking for detailed information regarding the operation of our Filter plans.

The applications of Drs. Wilma Weeks Rorick, U. of M. 1935, and of R. W. Kinzel, U. of Indiana 1936, were read a second time and, upon motion of Drs. Cooper and Lowe, Drs. Rorick and Kinzel were elected members.

Dr. Harvey Hansen made a report regarding the Filter Committee and suggested that one be set up in Albion now that Shelden Hospital is on the approved list.

Dr. Kenneth Lowe announced the resumption of the radio programs, the first broadcast to be Wednesday evening, November 3, at 7:15. The expense last year was \$40, made up by special subscription. Drs. Becker-Dodge moved that the program be sponsored by the Society again this year, and the expense, not to exceed \$40, be borne by the Society. Carried.

Dr. Harry F. Becker, acting for the Program Committee, introduced the speaker of the evening, Dr. Ward F. Seeley, Professor of Obstetrics and Gynecology, Wayne University, who talked on "Heart Disease in Pregnancy." He used the lantern in his talk. The discussion was participated in by Drs. L. E. Verity, C. R. Hills, Geo. W. Slagle, J. E. Cooper, F. J. Melges, H. M. Lowe, Stanley Lowe, W. H. Stadle, and W. F. Seeley.

Dr. F. E. Schmidt, of the Lederle Laboratories, presented a movie demonstration of the latest work in typing pneumonia and its treatment by sera.

### CHIPPEWA-MACKINAC COUNTY

DWIGHT F. SCOTT, M.D.  
*Secretary*

At the annual meeting of the Chippewa-Mackinac County Medical Society the following officers were elected for 1938:

President—J. F. Darby, St. Ignace.  
Vice President—J. G. Blain, Sault Ste. Marie.  
Secretary-Treasurer—D. F. Scott, Sault Ste. Marie.  
Delegate—E. S. Rhind, Rudyard.  
Alternate Delegate—J. A. Reese, De Tour.

### GENESEE COUNTY

C. W. COLWELL, M.D.  
*Secretary*

Minutes of the meeting of the Genesee County Medical Society, held at Hurley Hospital, November 24, 1937. In the absence of the president and president-elect, the meeting was called to order by the secretary.

After the reading of some communications by the Secretary, it was moved by Dr. Bogart that Dr. Kathryn Rose Lavin be accepted as a member of the Genesee County Society on a transfer from the Lackawanna County Society in Pennsylvania. Seconded and passed.

The only other official business transacted at this



meeting was the election of officers, results of which were as follows:

President-Elect—Dr. Leon Bogart.  
 Secretary—Dr. C. W. Colwell.  
 Treasurer—Dr. V. Morrissey.  
 Medico-Legal Officer—Dr. H. E. Randall.  
 Three-year Delegate—Dr. F. E. Reeder.  
 Three-year Alternate Delegate—Dr. D. Wright.

Following the election a very interesting lecture on Endocrinology, with lantern slides, was given by Dr. D. K. Kitchen and Dr. R. L. Schaeffer.

### HOUGHTON-KEWEENAW-BARAGA COUNTIES

C. A. COOPER, M.D.  
*Secretary*

Twenty-five members of the Houghton County Medical Society gathered for dinner at the Miscowabik Club, Calumet, Tuesday, December 7, in honor of Drs. R. J. Maas and W. P. Scott of Houghton, recently elected members emeritus by the House of Delegates of the Michigan State Medical Society.

The committee, Drs. A. LaBine and L. S. Leo of Houghton, and J. B. Quick of Laurium, arranged a five-course dinner of blue-points, boned squab, Miscowabik potatoes, green peas, head lettuce salad, baked ice cream, rolls and coffee. Dr. A. C. Roche of Calumet gave an impromptu entertainment of assorted college yells and stories between courses.

The guests of honor were introduced by Dr. LaBine. Dr. Maas said the changes in practice of medicine were well-known to all of us, so he would reminisce of his early days. Born Dec. 20, 1855, at the old Cliff Mine, in Keweenaw, his family later moved to Negaunee. Dr. Maas recalled a prejudice of his mother's, when she said no son of hers would be a doctor, butcher, or tailor. However, he became a doctor, though not a drunkard as his mother had feared, and just out of medical school (McGill, 1880) agreed to take care of the doctor's practice in his home town of Negaunee during the doctor's absence. Extraction of teeth was a part of his job, and he became quite a proficient "puller." A little later, in a mining practice of his own, he encountered a hernia case, and, with two other doctors, proceeded to do the first herniotomy in Marquette County. This was so successful, the doctor says his head increased in size considerably, but not for long. A short time later he made the diagnosis of femoral hernia on a woman who had fallen astride a chair, and operated. On incising the "sac," a large clot was expressed, and the "hernia" was gone.

Dr. Maas later came to Houghton, being surgeon for the Franklin Mine for many years, and a charter member of the Houghton County Medical Society. In concluding his remarks, Dr. Maas read a list of members who have "passed to their reward," and recalled incidents from years of association with them.

Dr. LaBine next called on Dr. W. P. Scott. Dr. Scott was born February 18, 1858, and graduated from Detroit College of Medicine in 1884. He practiced first in the iron country for a few years. He says that in his early years of practice he never saw or diagnosed "appendicitis," and, inasmuch as no patient died of severe gastro-intestinal complaints; he does not believe the failure of a diagnosis of appendicitis was detrimental to those patients. Later he with others began taking out appendices, and he recalls how innocent-appearing their first specimens were. Later, more pronounced pathology was found.

A little later he was persuaded to enter a venture

on Isle Royale, and recalled the vicissitudes of life on that island, isolated from all communication for five months, with no hospitals, no consultants, no nursing facilities, scanty supplies, and no possibility of replenishing them. During a forest fire on the island, the camp was in great danger, while on account of a violent storm the bay was impassable for boats. The forests, Dr. Scott recalled, were denser, and very dark and still. Even the birds would not stay in them.

On leaving the island, the steamer struck a rock, but proceeded to Houghton. It was later found the keel had been ripped off.

Dr. Scott entered practice in Houghton and Hancock, and in 1894 helped to organize the Houghton County Medical Society. He was its sixth president, and a respected member ever since.

Members present extended to the honored guests their congratulations and best wishes for many more years of friendly association.

### JACKSON COUNTY

H. W. PORTER, M.D.  
*Secretary*

The November meeting of the Jackson County Medical Society was held at the Hotel Hayes on Tuesday evening, November 16, at 6:30 p. m. Following the dinner the meeting was opened by the secretary. He first reported that the president, Dr. E. D. Crowley, is very much better but is still unable to attend any meetings or have office hours. The president-elect, Dr. John Van Schoick, is away on a hunting trip.

The name of Dr. J. L. Hoernschemeyer, having been approved by the board of directors and the membership committee, was presented to the society and he was unanimously elected. The doctor is a graduate of the St. Louis University School of Medicine, class of 1929, and is assistant physician to the Southern Michigan Prison.

The United States Chamber of Commerce mailed out three questionnaires concerning the possible change and improvement of standardized forms for the report of births, deaths and stillbirths. All county societies were contacted in this matter and the chair appointed Drs. Peterson, Geo. Pray and Corwin Clarke to attend to the matter locally.

Dr. Phil Riley spoke briefly on a syphilis survey that is now being made by the health department of Ingham County.

The secretary made a résumé of the principles and proposals of The Committee of Physicians concerning which there has been much in the magazines and newspapers recently.

Dr. Glen C. Hicks then took over the meeting and introduced the speaker, Dr. Harold L. Morris of Detroit, whose subject was "Cancer of the Bladder."

The meeting was thrown open for discussion and Dr. Morris answered the questions that were asked by various members from the floor and the meeting was then adjourned.

### KALAMAZOO-VAN BUREN COUNTIES

LOUIS W. GERSTNER, M.D.  
*Secretary*

The November meeting of the Kalamazoo Academy of Medicine was held November 16, 1937, in the Academy rooms. Dr. William Hoebeke, president, presided.

## COUNTY SOCIETIES

Dr. I. W. Brown presented resolutions in memory to Dr. Edward J. Nook.

Dr. L. R. Banner, who had been appointed by Dr. Hoebeke to draft a form for registry of Academy physicians, presented the following:

### "The Kalamazoo Academy of Medicine Registry

1. Name.
2. Date and place of birth.
3. Parents and other children in family.
4. Early childhood and elementary education.
5. High school education. Dates.
6. College education. Dates.
7. Medical school education. Dates.
8. Postgraduate internship, hospital work, army service. Dates.
9. Private practice, specialties. Dates and places.
10. Family, maiden name of wife, children, hobbies, all official positions.

Please fill in and mail to secretary, with photograph, 3x4. This will be placed on permanent file for future reference."

Moved by Dr. Armstrong, seconded and approved, that the form be accepted; and that future applicants to the Kalamazoo Academy of Medicine be required to furnish such form along with photograph on application for membership.

Dr. Hoebeke appointed the nominating committee for 1938, consisting of Dr. Leo Westcott, chairman; Drs. Paul Schrier and S. E. Andrews.

A committee with Dr. C. E. Boys, chairman, and Drs. R. A. Morter and K. L. Crawford, was appointed to study and make recommendations to the Federal Board of Vital Statistics regarding the death certificate, birth certificate, and a certificate for stillbirths.

On motion of Dr. Louis W. Gerstner, a committee was appointed to suggest a fee schedule for charges to applicants, for examination under the new Antenuptial Law. Dr. Hoebeke appointed Dr. C. L. Bennett, chairman; Drs. A. A. McNabb and L. H. Stewart to act on this committee.

Dr. C. L. Bennett moved that a committee be appointed to recommend changes in that sentence of Chapter 1, Sec. 3, of the By-Laws of the Kalamazoo Academy of Medicine which reads: "An applicant must have resided in the community one year before he may be accepted as a member." Motion carried. Dr. Hoebeke appointed Dr. C. L. Bennett, chairman; Drs. A. A. McNabb and L. H. Stewart (Medico-Legal Committee) to this committee.

Applications for membership of Drs. Edwin Terwilliger, Keith Bennett and Clarence M. Schrier were read for the second time. On motion of Dr. L. E. Westcott these three applicants were unanimously elected to membership.

Dr. B. A. Shepard, president of the Kalamazoo Tuberculosis Association, discussed the new product, Tuberculin-P.P.D., comparing it with the old tuberculin. This was an interesting discussion and well worth our while.

Business meeting adjourned.

## LAPEER COUNTY

CLARKE DORLAND, M.D.

*Secretary*

Doctor J. Orville Thomas, the retiring President, gave a complimentary dinner December 9 at Frankenthuth to the Members of the Lapeer County Medical Society.

The dinner was well attended and so much enjoyed that it almost turned out to be an endurance contest in eating; however, our most famous eaters finished a tie so there was no trouble.

After the dinner the regular monthly meeting of the Society was held with the election of officers for the ensuing year resulting as follows:

President—Dr. G. C. Bishop, Almont.

Vice President—Dr. H. B. Zemmer, Lapeer.

Secretary and Treasurer—Dr. C. C. Jackson, Imlay City.

Delegate to the Michigan State Medical Society meeting—H. M. Best, Lapeer, Michigan; alternate delegate D. J. O'Brien, Lapeer, Michigan.

Rev. Father McGinnis of Burnside, who was present as a special guest of Dr. Thomas, was asked to give a few remarks. In his usual genial manner he expressed his pleasure at being permitted to attend this dinner with the Doctors as he felt that our fields of endeavor brought us many things in common. He had always found Dr. Thomas willing and ready to assist in every way he could in all cases of trouble and distress.

Dr. H. E. Randall of Flint was the speaker of the evening. He gave a very interesting talk about his recent trip to Europe, giving in detail many points of interest he visited in Scotland, England and France. There were some parts of his visit in Paris that he did not detail so much, allowing his hearers to imagine the fine points.

A rising vote of thanks was given Dr. Thomas for his splendid dinner and evening.

Meeting adjourned.

## MANISTEE COUNTY

C. L. GRANT, M.D.

*Secretary*

The Manistee County Medical Society elected their officers for 1938:

President—Kathryn M. Bryan, Manistee.

Vice President—D. A. Jamieson, Arcadia.

Secretary-Treasurer—C. L. Grant, Manistee.

Delegate—E. A. Oakes—Manistee.

Alternate—L. W. Switzer—Manistee.

At the meeting of December 13 members of the Manistee Dental Society were invited guests.

## MUSKEGON COUNTY

LELAND E. HOLLY, M.D.

*Secretary*

The November meeting of the Muskegon County Medical Society was held at the Occidental Hotel on Friday, November 17, 1937. Following the dinner, the meeting was called to order at 7:50 P. M. by President C. B. Mandeville. There was a reading of the communications and bills. It was moved and supported that the bills be allowed as read. Motion carried.

Dr. Bartlett introduced his guest, Dr. Cordes of Leland. There was a discussion of the fees charged for Industrial Examinations of employees coming under the Occupational Disease Act. It was moved and supported that the President appoint a committee to draw up an official examination blank for the examination of employees. The motion was carried.

The president called attention to a recent resolution of the Directors of the Participating Association in which they propose that the County Society will receive not more than 50 per cent of the net income of the Participating Association in any one year. It was suggested by the Participating Association that the County Society raise any additional funds by special assessment and that those members not meeting their assessments be dropped from membership in the County Society.

The matter of the Afflicted Child's Act was again discussed. Members must remember that every case sent in under the Afflicted Child's Act will never again be a private patient. A list of the number of cases each man sent in was read. We must cut down the load.



**NORTHERN MICHIGAN**

W. E. LARSON, M.D.  
*Secretary*

At the annual meeting of the Northern Michigan Medical Society held December 9, 1937, the following officers for 1938 were duly elected:

President—Buell H. Van Leuven, M.D., Petoskey.  
Vice President—F. F. Grillett, M.D., Alanson.  
Secretary-Treasurer—W. E. Larson, M.D., Levering and Petoskey.  
Delegate—F. C. Mayne, M.D., Cheboygan.  
Alternate—F. H. Lashmet, M.D., Petoskey.

In answer to the request for suitable members to aid in deciding questionable occupational disease cases the following names were chosen by the society:

*Cheboygan County*—Dr. F. C. Mayne, Cheboygan; Dr. A. C. Christie, Cheboygan; Dr. W. F. Reed, Cheboygan.

*Emmet County*—Dr. W. H. Mast, Petoskey; Dr. W. E. Larson, Levering; Dr. R. D. Engle, Petoskey.

*Charlevoix County*—Dr. R. B. Armstrong, Charlevoix; Dr. H. M. Harrington, East Jordan; Dr. G. C. Conkle, Boyne City.

*Antrim County*—Dr. John Rodgers, Bellaire; Dr. J. Van Dellen, Ellsworth; Dr. D. H. Duffie, Central Lake.

These are the same men who are the Medical Filter Committees for their respective counties.

**OAKLAND COUNTY**

O. O. BECK, M.D.  
*Secretary*

At the annual meeting of the Oakland County Medical Society held on December 1, 1937, the following men were elected to serve the Society during the year 1938:

President—Dr. Aaron Riker, Pontiac.  
President-Elect—Dr. George Sherman, Pontiac.  
Secretary—Dr. Otto O. Beck, Birmingham.  
Treasurer—Dr. Hugh Williams, Pontiac.  
Delegates—Dr. Palmer Sutton, Royal Oak; Dr. Zea Aschen Brenner, Farmington; Dr. Otto Beck, Birmingham.  
Alternates—Dr. Ernest Bauer, Hazel Park; Dr. L. A. Farnham, Pontiac; Dr. A. V. Murtha, Pontiac.

**O.M.C.O.R.O. COUNTY**

C. G. CLIPPERT, M.D.  
*Secretary*

The annual meeting of the O.M.C.O.R.O. County Medical Society was held at the Nurses Home, Grayling, Michigan, December 2, 1937.

The following officers were elected for the year of 1938:

President—Dr. Levi Harris, Gaylord.  
Vice President—Dr. M. Martzowka, Roscommon.  
Secretary-Treasurer—Dr. C. G. Clippert, Grayling.  
Delegate—Dr. C. R. Keyport.  
Alternate—Dr. C. G. Clippert.

We had a very interesting meeting with fifteen in attendance.

**SAINT CLAIR COUNTY**

G. M. KESL, M.D.  
*Secretary*

A regular meeting of the Saint Clair County Medical Society was held Tuesday, November 2, 1937, at the Harrington Hotel, Port Huron. Dr. C. A. Macpherson, President-Elect, presided. A very fine

attendance was noted. The following physicians from Sanilac and Lapeer County Societies were present as visitors: Kircher of Sandusky, Webster and Gift of Marlette, Jackson and Berghorst of Imlay City, Bishop of Alamont. The following physicians not as yet members of the Saint Clair County Society but engaged in practice in this County attended: R. R. Likker and C. S. Martin of Port Huron and MacNeill of Capac. Douglas Treadgold, a former member of the Society practicing in Port Huron, was present, as was R. J. Biggar, Resident Physician of Port Huron Hospital. In all perhaps thirty-five members of the profession gathered to hear Dr. Frederick A. Collier, Professor of Surgery, University of Michigan, deliver a very fine talk on, "The Surgical Abdomen." Discussion and a rising vote of thanks to Doctor Collier preceded adjournment.

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The second meeting of the month was held Tuesday, November 16, 1937, at the Harrington Hotel, Port Huron. Supper was served to seventeen members and three guests. The Secretary-Treasurer at the request of Dr. C. A. Macpherson, presiding officer, read an announcement concerning the meeting, December 1, of the Highland Park Physicians' Club and also the data contained in Secretary's Letter No. 20 of the M.S.M.S. The matter of having a "State Society Night" was discussed by Councillor Heavenrich, who advised that we plan such a meeting in the Spring and not during the Winter. Dr. Macpherson then introduced the guest of the evening, Dr. Fred H. Cole of Detroit, who, with the aid of a series of lantern slides, spoke upon the subject, "Obstruction at the Vesical Neck." Dr. Patterson opened the discussion and was followed by Drs. Thomas, McColl and MacKenzie, after which Dr. Cole concluded the discussion. Dr. Macpherson and the Society expressed their thanks to the speaker for making the journey from Detroit and for giving us all such a fine instructive talk. Meeting adjourned.

**TUSCOLA COUNTY**

ROBERT R. HOWLETT, M.D.  
*Secretary-Treasurer*

The regular monthly meeting of the Tuscola County Medical Society was held November 11 at Murray Hall, Wahjamega. An election of officers was held with the following results: President, Lloyd L. Savage of Caro; president-elect, B. H. Starman of Cass City; secretary-treasurer, Robert R. Howlett of Caro. A short informal talk was given by Councillor W. E. Barstow of St. Louis on President Cook's program for the next year. A discussion of details of the Antenuptial Medical Examination Act and a general business session concluded the meeting.

**WASHTENAW COUNTY**

L. J. JOHNSON, M.D.  
*Secretary*

The November meeting of the Washtenaw County Medical Society was held at the Michigan Union, November 9, 1937.

President Reed Nesbit presided.

The Censor Committee presented the application of Dr. Hugh M. Beebe. Unanimously accepted into membership.

Dr. Marianna Smalley reporting for the Tuberculosis Committee stated that the Parent-Teachers

(Continued on page 91)

## WOMAN'S AUXILIARY

### REPORT OF STATE MEETING

To you who are our loyal members and were not in attendance at the Convention in Grand Rapids we owe this report of the very successful State Meeting.

To you, the committee of members of the Woman's Auxiliary to the Kent County Medical Society, we express our gratitude and appreciation. We feel sure that the outstanding success of the convention was a compensation for the great amount of time and effort involved.

A goodly attendance at the pre-convention Board Meeting made the discussions valuable to Board members.

The banquet held at the Pantlind Hotel was well attended, and members and guests were fortunate in being privileged to hear Mrs. Augustus S. Keck, National President of the Woman's Auxiliary of the American Medical Association, speak on the subject "The Doctor's Wife." The lives of Dr. Joseph Baron Lister and Dr. William Crawford Gorgas, their contribution to modern medicine and surgery, and the part their wives played in bringing about the success of these great men formed the foundation of this very interesting talk.

The next morning the press submitted the following ten commandments for Doctors' Wives — try them on yourself:

She must be a good business woman and maintain a good appearance on a limited budget. The average doctor's income is \$2,500.

She must be intelligent and able to meet her husband on an equal intellectual basis.

She must be patient and possess a sense of humor.

She must be diplomatic, standing as she does between the public and a tired, overworked man.

She must not become angry at broken social engagements or late meals.

She must be ready to carry on for him in civic and religious ways.

She must combine abilities of a nurse, secretary and telephone girl.

She must have social poise and steady nerves.

She must never violate a doctor's confidences.

She must refrain from gossip.

The business session, which was carried through so admirably by the president, Mrs. A. V. Wenger, embodied not only reports of all Board members, including county presidents, but the presentation and adoption of a new constitution and by-laws by the Revision Chairman, Mrs. J. H. Dempster.

Dr. Dempster, editor of THE JOURNAL of the Michigan State Medical Society, spoke briefly on the rules and regulations regarding the material submitted for publication in the Woman's Auxiliary section.

A beautifully appointed luncheon at the Kent County Country Club was attended by some two hundred members and guests when we received greetings from officers of the State Medical Society, Dr. Henry Cook, State President; Dr. A. B. Smith, President of Kent County, and Dr. L. F. Foster, Secretary, who presented a check for one hundred dollars (\$100.00), a gift of Michigan State Medical Society to defray expenses. Dr. Henry A. Luce, President-Elect, spoke on "Mental Hygiene," and Mrs. Augustus S. Keck again delighted her audience as she spoke on "Auxiliary Service," instituting

recommendations for the creation of benevolent fund.

A new year and new ideas were presented at the post-convention board meeting, at which time Mrs. G. C. Hicks presided.

Grand Rapids affords many pleasures and privileges for entertainment and we are deeply grateful to those who welcomed us so wholeheartedly and entertained us so delightfully.

Respectfully submitted,  
CONVENTION COMMITTEE,  
Auxiliary, Michigan State Medical Society

### A MESSAGE FROM THE HONORARY STATE PRESIDENT

Responding to the joint invitation of the State President and the State Press Chairman, we have the following inspirational message from our Honorary State President:

During the past months the newspapers and radio have been full of arguments by Labor demanding shorter hours and more wages. Demagogues have described as particularly ruthless a system which they call "Speedup," claiming that it crushes the life out of workmen and incapacitates them for the normal pleasures of leisure.

I have no intention of discussing the debate between Capital and Labor. I merely mention it because I suspect many members of our Auxiliary have frequently wished that some system might be devised that would put some regularity into a physician's life and reduce to a marked degree the demands upon his time and energy—demands which frequently bring him to the verge of collapse. Desirable as such an arrangement would be, it will not come to pass until mankind has mastered the science and technic of proper living. Meanwhile, conditions as they are give us an opportunity to be true auxiliaries to our husbands, who have chosen this great service profession as their life work.

You have all heard the adage "Familiarity Breeds Contempt." I wish I might coin a brief paraphrase to describe what I mean, but, since I cannot, may I explain in detail?

During courtship and the first months of marriage we are enthusiastic over the great work our husbands are doing. As time slips by swiftly the novelty wears off and we may become engrossed in our social life, our home and our children. Life and work have changed for us. This is the critical point in our lives and upon our handling of the situation hinges the question as to whether or not we continue to be a help and inspiration to our husbands, or in ways, not always recognized even by him, become an added burden to his already heavy load. We must always remind ourselves that his work and responsibilities have not changed in essentials. It is of the greatest importance that we do not lose our sense of perspective and allow social and home interests to assume the position of prime importance, and expect the world, including our husbands, to revolve about that center.

I appreciate that some young wives may criticize this attitude as "old fashioned"; but while fashions in many unimportant things may change, the good old standard virtues remain the same. It would be well for us from time to time to read again the



Hippocratic oath our husbands have taken and to follow that with a review of the story of Ruth. With that inspiration we will pledge ourselves anew to the great calling of being true helpmates to men engaged in the greatest profession in the world.

(Mrs. Guy L.) JOSEPHINE H. KIEFER

## EXECUTIVE BOARD MEETING

The midwinter meeting of the Executive Board, Woman's Auxiliary, Michigan State Medical Society, was held at the Hayes Hotel, Jackson, on December 6. In spite of the inclement weather, a good number were in attendance. The meeting opened with a luncheon at 12:15, at which Dr. Philip Riley, of Jackson, Speaker of the House of Delegates, talked briefly on the Basic Science Law, State Medicine, and the newly formed Health League. The interest aroused by his address was reflected in the discussion which followed.

In the business session which followed, reports from the state officers outlined plans for the year and methods by which these plans were to be put into action. One of the most helpful and constructive reports was that coming from the Advisory Council, which gave evidence of a real effort on the part of this group to outline policies for the Auxiliary which were inspiring, yet practical.

Following this came reports from county presidents, each one having something of help to the others, since no two seem to be doing exactly the same type of work, though the principles of the Auxiliary are back of them all. Adjournment was followed by an informal tea with opportunity for further exchange of ideas.

(Mrs. J. W.) ETHEL BOYD PAGE, *Secretary*

## PUBLIC RELATIONS

It has become very apparent, in all professions and businesses, that the need of adequate Public Relations departments are essential to their successful operation. This has been more noticeable during the recent years, when such changes have occurred in our social order.

The Michigan State Medical Society has given much time and effort to its Public Relations development. It has developed, out of the need for detailed integration of its plans and programs, the necessity of creating an informed public.

Probably no profession has felt more the need of defending its traditions and ideals than the medical profession. It has found itself beset on all sides by forces tending to destroy its long established principles.

The Woman's Auxiliary has as its greatest justification for existing an obligation to assist its parent organization in its attempt to publicize scientific medicine and to inform the public properly in the social aspects of sickness. The many unique contacts of physicians' wives provide an ideal opportunity to render a most valuable service to organized medicine.

It is the sincere objective of the Public Relations Committee of the Woman's Auxiliary to the Michigan State Medical Society, during the coming year, to develop an efficient publicity campaign along the lines developed by the medical profession and among the many and varied organizations particularly contacted by women.

(Mrs. A. L.) DORIS M. ZILIAK,  
*Chairman Public Relations Committee*

## HYGEIA

The year 1938. May I extend my best wishes to the members of the Michigan Auxiliary to the American Medical Society and wish each of you a year of success and happiness.

Success and happiness—how much health controls these two factors. Would it not be grand if only a wish could bring us all and everyone this magnificent factor of health? Sad to say, this is untrue, but, fortunately we as doctors' wives can do many things to promote health. The organization of our auxiliary was only the beginning, but most certainly an essential step. From there we are stepping forward, individually and as a group, to carry knowledge and understanding to those less fortunate. Our interpreter is *Hygeia*. We have adopted *Hygeia* because of its being the only direct printed information for the layman from the American Medical Association. We all realize it is a noble project, not only to teach those less informed, but to develop their interest in health and build up a partnership and understanding with the doctor.

The national program for the distribution of *Hygeia* has been formulated by our national chairman. In this program she includes this slogan, "The Woman's Auxiliary 100 per cent Subscribers." Here is our chance to work as individuals. Are we going to miss it? Of course not. We must each follow this suggestion and distribute the information offered us in *Hygeia* to as many persons as possible. Place your used copy in some home, public place, your doctor's office, or any of the hundreds of places where many benefit by its contents.

Another objective she sends is to place *Hygeia* in the public schools. The school child's mind is pliable and in a state of receptiveness. Health education can not be transmitted to the child too early in his life. The repetition of health training from the teacher and from the parents is an impressive factor to establish the correct habits of living.

It is therefore up to us to provide this information so necessary for the health of our future generations, both to the parent and to the teacher.

Let us, the Woman's Auxiliary of the American Medical Association, pledge ourselves individually to promote health education by being responsible for the guidance of *Hygeia*, and as a group being responsible for the accessibility of *Hygeia* to the teachers.

May none of us forget—Health—the leader of success and happiness, and work ardently for *Hygeia* subscriptions through December and January while special contest rates are offered.

(Mrs. L. R.) NATALIE KEAGLE,  
*State Hygeia Chairman*

## REPORT OF BOARD MEETING OF WOMAN'S AUXILIARY TO AMERICAN MEDICAL ASSOCIATION

It was a pleasure to represent the Michigan Auxiliary at the meeting of the Board of the Woman's Auxiliary of the American Medical Association, which was held at the Palmer House in Chicago, November 19. Twenty officers and chairmen of standing committees and fifteen state presidents were present. The reports, given by these women who had had years of experience in Auxiliary work, showed that there is a constantly growing interest, and real efforts are being put forth to combat all movements which have a tendency to discredit the medical profession as it is practiced today.

A new and revised "Handbook" has recently been printed, and it embodies the duties of all the chairmen of standing committees. Be sure to keep in

mind the December and January reduced rates for subscription to the *Hygeia* magazine. A real reward is to be taken by some state in the \$150.00 award offered by Mr. Cargill, circulation manager of *Hygeia* magazine.

Our chairman of organization is interested in memberships from unorganized sections of the State. Such memberships will be termed associate, the dues being one dollar (\$1.00) per year, seventy-five cents (75c) for state dues and twenty-five cents (25c) for national. All meetings at the conventions are open to the wife of every member of the Michigan State Medical Society. However, interest is much keener in any organization if one feels that one is a part of its membership. We are looking forward to a valuable increase not only in our membership, but to the number of Auxiliaries this year under the direction of Mrs. Henry J. Pyle. She is interested in hearing from any group contemplating organization.

Improve the program of your Auxiliary by becoming "More Auxiliary Minded" and conforming to the request for self-education on health subjects.

The program on the marihuana weed, its growth, manufacture, and the State and Federal laws regarding its dispensation, would prove to be very interesting and educational.

May I urge you to accept as many responsibilities in lay groups in your community as you are able to fulfill? By so doing you are preventing not only your Auxiliary, but your local Medical Society, from many complicating circumstances concerning health conditions. It is much easier to prevent discord than to relieve it.

I extend best wishes for a very interesting and profitable year to each and every Auxiliary member.

Respectfully submitted,  
(Mrs. G. C.) BERNICE HICKS,  
President

## COUNTY SOCIETIES

### Bay County

Officers and Chairmen in 1937-1938:

President—Mrs. A. L. Ziliak, Bay City.

President-Elect—Mrs. R. E. Scrafford, Bay City.

Vice President—Mrs. A. D. Allen, Bay City.

Recording Secretary—Mrs. W. G. Gamble, Bay City.

Corresponding Secretary and Press Chairman—Mrs. W. S. Stinson, Bay City.

Treasurer—Mrs. R. M. Gale, Bay City.

Telephone—Mrs. F. P. Husted, Bay City.

Program—Mrs. R. C. Perkins, Bay City.

Membership—Mrs. C. A. Stewart, Bay City.

Social—Mrs. G. M. Brown, Bay City.

Hygeia—Mrs. A. D. Allen, Bay City.

The first meeting of the Auxiliary of the Bay County Medical Society was held on October 7. There was no regular business meeting, as our guest speaker was Dr. Morris Fishbein, and the dinner with program following was open to the public. We felt this was one of our most successful ventures since the founding of our organization. Two hundred and seventy-five people were present and Dr. Fishbein was received with great acclaim. Others among our guests were Mrs. G. C. Hicks, State President, and Mrs. A. V. Wenger, Past President.

On November 10 the Auxiliary met for dinner at the Hotel Wenonah. Twenty-five members were

present. Plans were made for a membership drive, this to be concentrated especially upon the wives of doctors residing outside of Bay City. The question of "putting *Hygeia* across" was then brought up, with considerable discussion resulting. We have never had much success in actually selling subscriptions to the magazine, so it was finally decided that the committee in charge should devise some scheme for raising enough money to pay for our quota of subscriptions for the year. These magazines are then to be placed in the rural schools throughout the country where they seem to be most appreciated. Plans are now well organized for a Keno Party for the doctors and their wives which is to be held December 1 at the Nurses' Home of Mercy Hospital. This, we feel sure, will more than provide us with the funds needed. Mrs. A. D. Allen, *Hygeia* chairman, is in charge of all arrangements for the party. The business meeting closed with a report from Mrs. R. E. Scrafford on the State Convention at Grand Rapids. Following this we joined the doctors in their meeting, that we might listen to Hon. Roy E. Woodruff, our Representative in Washington from this Congressional District.

(Mrs. W. S.) LYNN J. STINSON,  
Press Chairman

### Calhoun County

The members of the Calhoun County Medical Society combined their annual meeting with the Ladies' Night dinner for one hundred physicians and guests. The dinner was held at the Kellogg Hotel Tuesday, December 7, at six o'clock. The table decorations were in keeping with the Yuletide season. Following dinner the Reverend Carleton Brooks Miller, pastor of the Congregational church, gave an interesting talk on "Happy Convalescence."

DOROTHY G. LOWE,  
Press Chairman

### Eaton County

The first meeting for the year 1937-1938 of the Eaton County Medical Auxiliary was held at Green Meadows Tea Room, September 23. The following new officers took their chairs: President, Mrs. K. A. Anderson, Charlotte; vice president, Mrs. Lester Sevensen, Charlotte; secretary, Mrs. B. P. Brown, Charlotte; treasurer, Mrs. Paul Engle, Olivet.

The following committees were appointed by the president: Social—Mrs. Lawther; Program—Mrs. Van Ark, Mrs. Hargraves; Membership—Mrs. Huber, Mrs. Sassaman; Legislative—Mrs. Wilensky; Press—Mrs. Brown; Hygeia—Mrs. Newark; Public Relations—Mrs. C. J. Sevensen; Flowers—Mrs. Rickerd, Mrs. Sheets; Necrology—Mrs. Rickerd.

Plans for the year were discussed and amendment to constitution read in regard to membership of widows of deceased doctors.

\* \* \*

Following dinner at Green Meadows Tea Room on October 28, the Eaton County Auxiliary met at the home of the secretary for a program and business meeting.

A most interesting and instructive motion picture of the processess leading up to and through the making of Miller ice cream was shown by Charles Miller of Eaton Rapids.

Reports of the state meeting at Grand Rapids were given, reports by committee chairmen were



made, and new members were welcomed by the president.

November and December meetings were combined in the meeting of December 9 when the Medical Society entertained the Auxiliary.

(Mrs. B. P.) MILICENT BROWN,  
*Press Chairman*

### Jackson County

The November meeting of the Woman's Auxiliary of the Jackson County Medical Society was held at the home of Mrs. Don Kudner on Tuesday evening, November 16. The 6:30 dinner was in charge of and served by a committee composed of Mesdames N. D. Wilson, chairman, H. W. Porter, W. E. McGarvey, J. B. Meads, H. A. Brown and T. E. Schmidt. Buffet service was used and the beautifully appointed table was accentuated with a lovely centerpiece of pale pink chrysanthemums and silver leaves. Roast turkey was carved and served from one end of the table.

Following the dinner, a short business meeting was conducted by the county president, Mrs. John Ludwick. One matter of great importance which was brought up at this time was the project of the newly formed Ways and Means Committee. It has been decided to give some concrete help to the children's wards of each of our two largest hospitals—the W. A. Foote Memorial and Mercy. After some discussion upon that subject, the topic was tabled to give the members more time to think about what they wanted to do. The State Board meeting, which will be held at the Hayes Hotel in Jackson at 12:15 on Dec. 6, was announced.

Following the business session, many of the members left the meeting to hear W. A. Cameron give a talk at the Jackson High School that evening. For those who remained at the Auxiliary meeting, bridge was the diversion. Mrs. E. H. Corley was the social chairman.

ANNA HYDE SHAEFFER,  
*Press Chairman*

### Kalamazoo

An outstanding meeting from the medical viewpoint was held in November at the home of Mrs. K. L. Crawford, with an attendance of 40. After the usual coöperative dinner Mrs. Crawford as Program Chairman gave a very appreciative introduction of the speaker of the evening, which did just credit to the fact that the best specialists are conversant with the all-round factors of good medicine. Dr. C. B. Fulkerson, member of our Advisory Council, spoke on a "Dramatic Episode in Medical History," which was both educational and most interesting. He held his audience in his vivid description as he reviewed episode after episode of Dr. Wm. Beaumont's work with his patient Alexis St. Martin at Mackinac in early Michigan history, which gave to medicine the modern conception of the physiology of the stomach.

The interest of the audience more than repaid for there being so numerous counter attractions in music and drama on this same evening. The Doctor was tendered a gracious vote of thanks.

Mrs. W. W. Lang gave an interesting deferred report of the State Meeting in Grand Rapids.

The *Hygeia* chairman, Mrs. S. E. Andrews, urged that each member be responsible for one subscription to *Hygeia*.

The Auxiliary voted to pay the tuition of a to-

tally deaf child to the Harding School, also to send gifts of food or clothing (to be brought to the joint December meeting) for the aged to the Community Christmas Tree as of the past three years. Four new members were welcomed.

(Mrs. Hugo) BARBARA K. AACH,  
*Publicity Chairman*

### Kent County

The Kent County Women's Medical Auxiliary, under the chairmanship of Mrs. William J. Butler, chairman of the *Hygeia* committee, and Mrs. John M. Whalen, chairman of the Philanthropic committee, staged a most successful bridge party on December 6 at the Fine Arts Building, Grand Rapids. About 250 auxiliary members and their guests enjoyed the afternoon together. The *Hygeia* and Philanthropic fund was increased by over \$88.00.

The members of the auxiliary and their husbands enjoyed a dinner dance at the Pantlind Hotel on December 18.

At the regular meeting, December 8, Dr. A. J. Baker, incoming president of Kent County Medical Society, spoke on the subject "Changing Trends in Human Illness." Of great interest to the doctors' wives was his discussion of how to diminish the possibilities of such diseases as diabetes and heart and intestinal disorders, all attendant on the hectic tempo of modern life. Mrs. F. A. Votey spoke on the subject of marihuana, its evils in general and its menace to Grand Rapids schools. A lovely Christmas tea was served by the teams of Mrs. John Ten Have and Mrs. R. E. Sculley. Mrs. William Butler and Mrs. William Torgerson were at the tea urns.

(Mrs. Robert M.) MIRIAM ADAMS EATON.

### Monroe County

Our Auxiliary is still so young, we feel we have much need of help and advice. In October we had an interesting dinner meeting. In November we had as our guest speaker, Dr. S. E. Gould, pathologist at Eloise Hospital, on the subject of "Cancer." We have formulated an outline program for the year, but desire help along organization and plans as we are groping in the dark aside from the helpful advice of the State Press chairman.

MRS. WM. W. BOND,  
*Press Chairman*

### Saginaw County

Members of the Saginaw County Medical Society were entertained at a delightful potluck supper given by the Medical Auxiliary Thursday evening at the Y.W.C.A. One hundred guests were in attendance.

Effective decorations of Christmas greens, white cellophane pompoms tied with red bows, crepe paper and red candles graced the supper table.

Prizes at games were awarded to Mrs. Gunther E. Tiedke, Mrs. Matthew Kollig, Mrs. Louis D. Gomon, Mrs. Cecil W. Ely, Mrs. Frank O. Novy, Mrs. John W. Hutchinson, Mrs. Lloyd C. Harvie, and Mrs. Thomas Flethner of Midland, Dr. Emil P. Richter, Dr. W. J. O'Reilly, Dr. Eustace C. Hester, Dr. Richard S. Ryan, Dr. Charles R. Murray and Dr. H. O. Helmkamp.

The entertainment committee, headed by Mrs.

(Continued on page 84)

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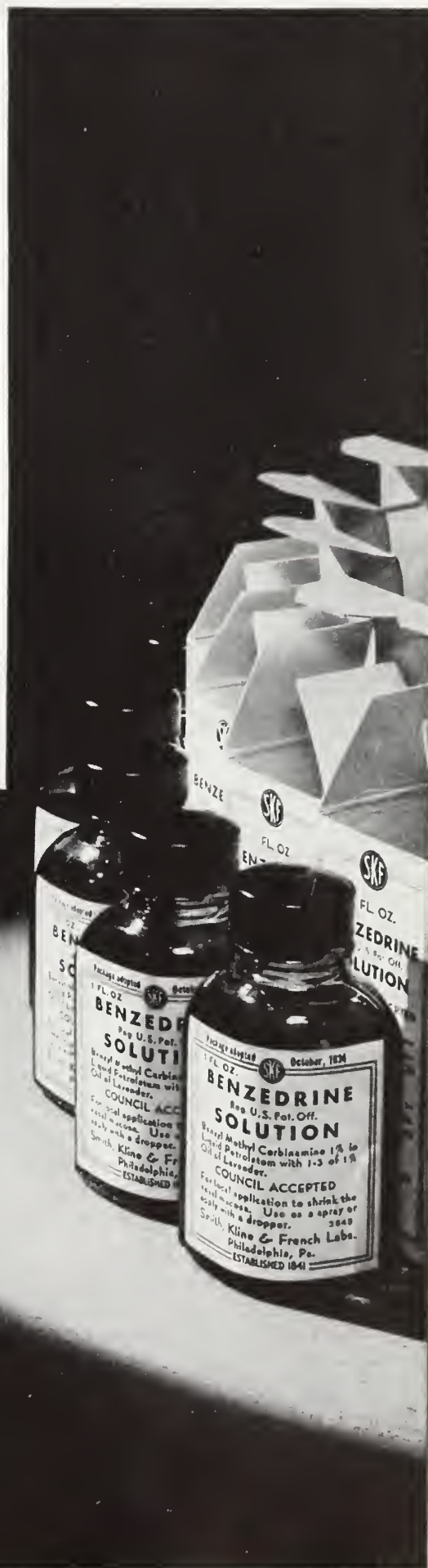
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Dale E. Thomas, was in charge of arrangements. Assisting her were Mrs. Tiedke, co-chairman, Mrs. Novy, Mrs. William K. Anderson, Mrs. Victor L. Hill and Mrs. Donald C. Durman.

### Wayne County

The Woman's Auxiliary of the Wayne County Medical Society began its tenth year on Friday, October 8, with a luncheon at the Detroit Boat Club on Belle Isle. There were about one hundred members and guests present.

Mrs. Roger V. Walker, reelected president of the auxiliary, presided at the speakers' table and introduced Dr. C. E. Umphrey, president of the Wayne County Medical Society. Dr. Umphrey thanked the Auxiliary members in the name of the Society for their work in the past and asked for their continued coöperation in entertainment for Medical Societies which will meet in Detroit during 1938. He also suggested that a house committee be appointed from the Auxiliary to consider changes and renovations to be made in the Society's club house on Woodward Avenue. He stressed the necessity of the doctors' wives being well represented in the other club groups throughout the county.

The speaker for the afternoon, Mrs. Frederick B. Fisher, who has spent many years in China, selected as her topic "When Women Doctors Entered the Orient."

There was no regular meeting in November, but instead there were two meetings sponsored by the Auxiliary and the *Detroit News* under the direction of our Public Relations Committee, of which Mrs. H. Wellington Yates is chairman, and of Sally Woodward, Radio Editor of W.W.J., the *Detroit News*.

These meetings were held on two successive Wednesdays, November 3 and November 10. At the first meeting there were two speakers: B. I. Johnstone, M.D., spoke on "The Heart," and Frank H. Purcell, M.D., spoke on "The Feet."

The November 10 meeting was in charge of Claire L. Straith, M.D., who gave an illustrated lecture on "Plastic Surgery." These meetings were primarily held to inform the laity on medical subjects and were very well attended by other club women, as well as our own group.

The December meeting of the Wayne County Medical Auxiliary was held on Friday, December 10, at 2:00 o'clock in the club rooms of the Society. A. Henry Reye, M.D., Professor of Neurology and Psychiatry of Wayne University, spoke on "Some Factors That Make Marriage Difficult." This was followed by a musicale tea, the soloist, Mrs. Horace C. Jones, accompanied by Mrs. Donald Fraser McDonald. The Auxiliary also held a children's Christmas party and puppet show on Saturday, December 18, under the sponsorship of the Wayne County Medical Society. Children of all the members were invited.

(Mrs. H. P.) HELEN R. DOUB,  
*Press Chairman*

Doctor Brown—I hear, Uncle Wash, that all your folks have the itch.

Old Negro—Yas suh, Doctah. De good Lawd has done 'flicted we-all dat way.

Doctor Brown—And are you doing anything for it, Uncle?

Old Negro—Oh, yas suh, Doctah, yas suh. We sho is.

Doctor Brown—What are you doing?

Old Negro—Why, suh, we-all is scratchin', suh.

## MICHIGAN'S DEPARTMENT OF HEALTH

C. C. SLEMONS, M.D., Dr.P.H., Commissioner  
LANSING, MICHIGAN

### MICHIGAN'S PLAN FOR SYPHILIS CONTROL

The five-point program of the Michigan Department of Health for combating syphilis which was outlined by Dr. C. C. Slemons, state health commissioner, at the Seventeenth Annual Public Health Conference will include the free distribution of antisyphilitic drugs to physicians for treating patients unable to purchase them; more rigid rules and regulations requiring the reporting of all cases and prompt, continuous treatment; the expansion of diagnostic laboratory facilities; the creation of a special division of syphilis control within the department; and a more intensive general educational program.

The drugs to be distributed will include neoarsphenamine, mapharsen and bismuth subsalicylate. Full-time health departments in Detroit, Grand Rapids, Flint, Saginaw, Pontiac, Lansing, Jackson, Kalamazoo, Battle Creek and Marquette will serve as distributing stations. The 34 county and district health departments will also serve the physicians in their vicinity. The remaining 27 counties will be served directly by the Michigan Department of Health.

Physicians may obtain the drugs by certifying that the patient is unable to purchase them. A separate request form must be made out for each patient. For the present, the size of any single order will be limited to eight ampules of arsenicals and one vial of bismuth. The drugs will also be supplied to all free venereal disease clinics. Blank forms for ordering drugs may be obtained upon request.

The new rules and regulations approved by the State Council of Health, November 11, 1937, provide that all cases of syphilis, gonorrhea and chancroid in any form or stage shall be reported immediately. The courts have interpreted "immediately" to mean "within the following 24 hours." New report forms have been prepared by the Michigan Department of Health and may be obtained upon request together with postage-free envelopes. The new report form is divided in two sections perforated through the center. The top section known as Report Form No. 1 will be used to make the first report of a case of syphilis, gonorrhea or chancroid by the name, initial or number of the patient. The lower section of the blank known as Report Form No. 2 will be used to report patients by name and address when they refuse to cooperate with the physician in securing adequate and continued treatment.

Approximately \$60,000 will be available for syphilis control activities during the year. Of this amount \$25,000 will be used for the purchase and distribution of drugs for the treatment of syphilis and for general administration of the program. Approximately \$10,000 will be spent for the usual serodiagnostic examinations for syphilis made by the department laboratories at Lansing, Grand Rapids, and Houghton. An additional \$25,000 has been allotted for an expansion of laboratory facilities to care for the increased demand for blood tests which the department must perform free of charge for marriage license applicants under the recent Antenuptial Physical Examination Act.

(Continued on page 86)



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Consider all this—top it off with Heinz *proved* quality reputation—and you'll agree Heinz Strained Foods are best for the infants in your care! Surely, they deserve your personal endorsement and outspoken recommendation.

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## NEW RULES AND REGULATIONS OF THE MICHIGAN DEPARTMENT OF HEALTH FOR THE CONTROL OF VENEREAL DISEASES

New rules and regulations of the Michigan Department of Health for the control of venereal diseases were approved by the State Council of Health on November 11, 1937, and became effective on that date. The new rules and regulations provide that *all cases of syphilis are now reportable*, whereas the former regulations required only *infectious* cases to be reported.

Physicians may report cases of venereal disease by name, initial or number. Health departments, however, desire physicians to avoid reporting by number if possible because of resulting duplication and lack of identification. These reports are confidential and are not public records. Reports are to be made to the local health officer in cities, counties and districts having full-time health departments and to the Michigan Department of Health in all cities and counties without full-time health departments.

The purpose of regulations No. 4 through No. 7 is to control the uncoöperative patient, to keep the venereal disease patient under medical care, and to bring possible sources and contacts under such care until permanently noninfectious and, if possible, cured. In all cases, health officers will consult with the attending physician to avoid taking any action which may react upon the professional relationship of the physician to his patient.

The official rules and regulations now in effect for the control of venereal diseases are as follows:

### Rules and Regulations for the Control of Syphilis, Gonorrhea and Chancroid

1. Reports of all types referred to in the following sections shall be made as follows:
  - a. In cities, counties and districts having full-time health officers, reports shall be made to the city, county, or district health officer.
  - b. In cities and counties without full-time health officers, reports shall be made direct to the Michigan Department of Health.

Necessary blanks have been prepared by the Michigan Department of Health and will be furnished upon request.
2. All cases of syphilis, gonorrhea and chancroid in any form or stage shall be reported immediately. (See Section 1.) The report shall contain the *name, initials, or physician's serial number; sex, birth date and community of residence of the patient; the name and stage or form of the disease; and the method of diagnosis*, as provided on Report Form No. 1.
3. The physician shall always ascertain if the patient was in consultation previously with another physician relative to the same infection. If so, and the patient is unwilling to return to his former physician, in order to avoid being reported by name and address as provided in the following section, the patient shall be instructed to notify said former physician of his change of medical advisor.
4. Whenever a person having syphilis, gonorrhea or chancroid shall fail to return to his physician for observation or treatment without offering reasonable proof of his inability to keep the appointment or to give satisfactory evidence that he is under other medical care, the physician shall report the same (see Section 1) within two weeks of the date of the missed appointment, giving the *patient's name, address, age and*

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*sex; and the stage or form of the disease, as provided on Report Form No. 2.*

5. Whenever a person with primary or secondary syphilis has lesions in the mouth or upon the exposed portions of the body and is employed in any occupation requiring regular direct contact with other persons (for example: barber, hairdresser, manicurist, waiter, waitress, nurse, nursemaid, domestic, et cetera), such persons may, at the discretion of the physician, be ordered to discontinue such occupation until two injections of suitable arsenical drug have been administered; and whenever the physician is not willing to assume responsibility for the obedience of the patient to this order, the *name, address, age, sex, occupation and disease of such person shall be reported immediately by the physician, as provided on Report Form No. 2.*
6. Whenever a person with acute or chronic gonorrhea is employed as nurse, nursemaid, or domestic, requiring regular direct contact with infants and (or) children under fourteen years of age, the physician shall take such procedures as will be necessary to prevent such person from continuing a possible source of infection to infants and children; and whenever the physician is not willing to assume responsibility for the obedience of the patient to such procedure, the *name, address, age, sex, occupation, and disease of such person shall be reported immediately by the physician, as provided on Report Form No. 2.*
7. The physician shall make every effort to identify and bring to medical observation those members of the patient's family or other contacts who may have been infected or exposed to the patient's infection, and if the patient refuses to

coöperate in such effort, he shall report (see Section 1) the *name, address, age and sex; and the name and stage or form of the disease of such patient.* The physician shall further attempt to identify those of the patient's other contacts from whom he may have acquired or to whom he may have transmitted infection, and if, within two weeks of such identification, a contact is known not to be under medical observation, the physician shall report the *name and address of such contact, as provided on Report Form No. 2.*

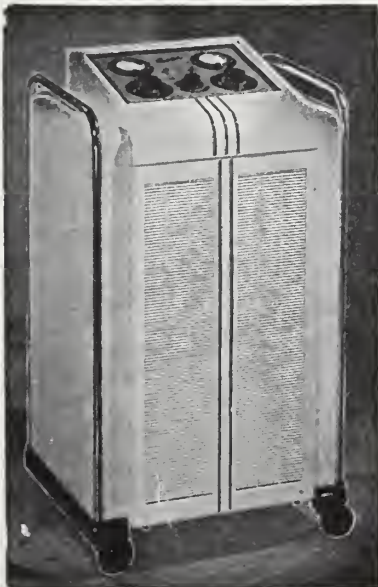
8. It shall be the duty of the city, county or district health officer (or his representative) in cities, counties and districts having full-time health officers and of the Michigan Department of Health in cities and counties without full-time health officers to consult with the attending physician in an effort to avoid taking any action that may react upon the professional relationship of the physician to his patient in accordance with these regulations.
9. Placarding, isolation, or quarantine shall not be used in the administrative control of these diseases in any case where the public health can be protected without these measures. These measures shall be used when necessary: (1) To insure the public against infection, and (2) to make certain that the patient receives adequate treatment.

#### SYPHILIS TREATMENT OUTLINES AVAILABLE

The Advisory Committee on Syphilis Control of the Michigan State Medical Society has prepared a series of recommended treatment schedules for various forms and stages of syphilis. The schedules

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outlined are in accord with the opinion of leading syphilologists, but they are not intended to be followed blindly in the presence of complications or contra-indications. The outlines are prepared for the drugs supplied free of charge by the Michigan Department of Health for patients unable to purchase them. The Committee feels that effective treatment can be carried out with these drugs in the great majority of cases (with the particular reservations for neurosyphilis and congenital syphilis mentioned in the outlines).

The outlines cover the following forms and stages of syphilis: early, late, syphilis of pregnancy, congenital, cardiovascular, neurosyphilis, and hepatic syphilis. These outlines have been assembled in pamphlet form and printed by the Michigan Department of Health. Physicians may obtain the outlines upon request to the Michigan Department of Health, Lansing.

### COMMUNICABLE DISEASES DURING 1937

The poliomyelitis season closed with the third highest number of cases reported in the state for any one year. The exact number for the calendar year is not known at this time, but it will be approximately 425. Six hundred and fourteen cases were reported in 1935 and 1,137 in 1931.

Diphtheria has continued to show an increase over that of last year, and during recent months the incidence has been above the five-year mean. The 1937 total, when figures are officially assembled, will approximate 900 cases. There were 661 cases reported in 1936. More immunization of infants is needed in order to stop this apparently natural trend toward a returning high incidence.

The official figures of reported cases of measles will undoubtedly show something in excess of 5,000 for the year. Part of this has been due to increasing incidence during November and December and is probably the beginning of the expected outbreak in the early months of 1938.

Reported cases of pneumonia indicate an incidence for the year of approximately 25 per cent less than for the year 1936.

It is expected that reported cases of meningococcic meningitis will be something less than 100. A total of 114 cases was reported in 1936.

The total number of cases of scarlet fever for 1937 will undoubtedly exceed 24,000. This is twice the number reported for 1936 and may be compared to 1934, the highest year heretofore on record, when 19,238 cases were officially reported. The increased incidence began in the latter months of 1936. For every month of 1937 there has been an increase over the corresponding month of the previous year. This increase has continued during the early winter months just past and perhaps will not return to normal before late in the spring of 1938.

The outbreak of smallpox occurring in Monroe County during the early months of the year caused by an out-of-state case, has been referred to in previous issues of THE JOURNAL. This outbreak has directly or indirectly accounted for about all but 25 cases of the total number for the year, which will be approximately 150. There were only 32 cases reported in the state for 1936 and 16 for 1935.

The year 1936 established a new low record of 287 cases of typhoid fever. It is expected that when the final figures are tabulated, the year 1937 will establish another lower record.

The incidence of whooping cough for 1937 has been about average. The number of reported cases for the year will be approximately 11,000.



## MEASLES

It is a well known fact that outbreaks of measles occur in quite regular cycles and may be predicted with more certainty than most any other communicable disease. For the small or medium-sized community such cycles occur most often at three year periods. For metropolitan areas such as Detroit this cycle is likely to be two years although occasionally it goes over until the third year. Measles also reaches its peak almost invariably during the spring months. These facts, together with the newer procedure of prevention or modification of measles by whole blood, serum, or placental extract, makes it possible for health officers to plan campaigns whereby the mortality from this disease may well be lowered.

There is an abundance of literature regarding work done with these three products in the prevention or modification of measles in those who have been exposed to the disease. No attempt will be made to review this literature or give references in this discussion. Generally speaking, authorities are for the most part agreed that these three products are all more or less efficient if used in proper dosage and at the proper time after the first day of the known exposure. If the injection of whole blood, serum, or placental extract is made during the first four or five days, there will be in a high percentage of cases a complete prevention of an attack. If made from the fifth to eighth day or perhaps the ninth after first exposure, the child will usually have a mild and greatly modified attack. The incubation period in such cases is usually long, the fever, if any, is slight and of short duration, the rash atypical, the cough is mild or absent, there is little or no coryza, a slight degree of bronchitis, and no pneumonia following. All degrees of modification up to failure,

where a severe case may result, are to be expected.

In general, placental extract may be expected to be of a more standard potency and the results theoretically should be more uniform. A number of writers have confirmed this in reports of their experiences.

Convalescent serum is perhaps next in order of preference as to uniformity of potency and results. A somewhat larger dosage in volume is required. It is difficult in most localities to obtain convalescent serum at a time when needed. Serum made from any normal group of adults, regardless of when they may have previously had measles, is also used. This is still less dependable and uniform in potency and requires a somewhat larger amount in dosage.

Lastly, whole blood may be taken from a vein of one of the parents who has previously had the disease and may be injected intramuscularly into the child to be protected. This method has the advantage of being nearly always available at no cost, but it has the disadvantage of requiring a relatively large amount of blood, several times greater than the dosage of placental extract. The potency of the blood of the parent is always unknown and the results are less dependable than from the other procedures.

The Michigan Department of Health is not providing placental extract or convalescent serum. The only material distributed is sterile 2 c.c. vials of sodium citrate, which may be used by the physician to facilitate the procedure of giving whole parental blood by preventing clotting and clogging of the needle.

Outbreaks of measles are expected to begin in most communities of the state sometime between December and April. It is true that in many instances parents will not know when their children are exposed. Health officers may well keep their



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communities informed as to when to expect the outbreak and to warn the public and physicians at the time the *first case* is discovered. By so doing and granted that practicing physicians are also on the alert, many parents will have an opportunity of notifying their physician as to when their child was exposed. Physicians are urged to take advantage of one of the procedures referred to in the case of all children under four years of age who are known to have been exposed. Health officers have been urged to aid physicians in every way possible by supplying them with information as to how and where placental extract may be obtained and the technic of administration of this product or whole blood.

In 1932, there were reported 42,129 cases of measles in the state. This was the highest number on record up to that time. Three years later, in 1935, there was recorded a total of 79,061 cases. In 1932, there were 183 deaths from this disease. In the great outbreak year of 1935 with almost twice as many cases recorded, there occurred only 184 deaths. Admittedly there is a natural trend toward a lower case fatality rate which is due to more or less unexplainable causes. However, it is believed that this reduction in case fatality of approximately 50 per cent in comparison of the two outbreaks, is due in part to the rather widespread use of the above mentioned procedures.

### OBSTETRICAL NURSING SERVICE IN CASS COUNTY

An obstetrical nursing service similar to that being conducted in 26 demonstration areas throughout the United States has been organized in Cass County by the Bureau of Maternal and Child Health with the coöperation of the local physicians and the county board of supervisors.

The new service will make it possible for nurses trained in obstetrical nursing to accompany physicians upon request at deliveries and provide necessary bedside care. Working closely with the medical profession, the nurses will attempt to reach every expectant mother and broadcast the need for adequate prenatal medical care. The service will not be of an emergency type. All cases must be registered in advance in order that nurses may make at least one call before the delivery. At least three or more calls will be made on mothers following delivery and members of the family will be instructed in necessary bedside care. No case will be accepted unless there is a physician in attendance, and obstetrical nursing service will be provided only upon the request of the attending physician.

Staff headquarters have been established in Dowagiac. Miss Violet Keller and Miss Harriet Hird, former obstetrical nurses with the Detroit Visiting Nurses' Association, will conduct the program under the supervision of Miss Mabel Munro, chief nurse. Miss Marian Buck will continue on the Cass County staff, carrying on the school health program. An additional obstetrical nurse will be provided when the demand for such services warrants it.

### BUREAU OF MATERNAL AND CHILD HEALTH

The title of the former Bureau of Child Hygiene and Public Health Nursing has been changed to the Bureau of Maternal and Child Health. The bureau, which is administering the extensive maternal and child health program provided by grants under the Social Security Act, will continue under the direction of Dr. Lillian R. Smith. Dr. G. B. Corneliussen is as-

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sociate director. A Division of Public Health Nursing will function within the bureau with Mabel G. Munro, R.N., as chief nurse, and Helen deSpelder Moore, R.N., as nursing advisor.

#### NEW DELTA COUNTY HEALTH DIRECTOR

Dr. Roelof Lanting has succeeded Dr. R. C. Farrier as director of the Delta County Health Department. Dr. Lanting is a native of Michigan, graduated from medical school of the University of Michigan, and also received his public health training at the University after his internship at Muskegon. He comes to his new position from Kentucky, where he was engaged in private practice and served as school physician. Dr. Farrier has accepted a position as health officer of East St. Louis, Ill.

#### TO IMPROVE INSTITUTIONAL SEWAGE DISPOSAL SYSTEMS

The Bureau of Maternal and Child Health will partment of Health will supervise the design and construction of the proposed improvements to the sewage disposal systems of all state institutions. Homer J. Hayward, sewage disposal plant designer, has been added to the bureau staff and at present is drafting plans for the improved system to be installed in the Michigan State Sanatorium at Howell. Later improvements are proposed for the sewage disposal systems at the Michigan Reformatory at Ionia and the Michigan Farm Colony for Epileptics at Wahjamega.

#### INGHAM COUNTY NUTRITION INSTITUTE

The Bureau of Material and Child Health will conduct a nutrition institute, January 24, in the assembly room of the department diagnostic laboratories at Lansing. Public health nurses of Ingham County and surrounding counties have been invited to attend. The institute will be conducted by Miss Elizabeth Whipple, staff nutritionist.

#### WASHTENAW COUNTY

(Continued from page 78)

Association of the High School had made arrangements with the University hospital for examination and study of High School students the same as they had done in the University. Dr. Smalley moved that the Secretary be instructed to send a letter to Mrs. Edward Bragg offering the Society's support to the project of examining High School students for tuberculosis. Seconded and carried.

President Nesbit appointed the following on the Nominating Committee: Dr. Samuel Donaldson, Dr. Henry Field and Dr. Fred Waldron.

President Nesbit read a letter from the Department of Commerce, Bureau of Census, Washington, asking our Society's help in drafting new certificate forms on birth, death and stillborn. He appointed the following Committee: Dr. John Wessinger, Chairman, Dr. H. H. Cummings and Dr. Norman Kretzschmar.

The scientific program consisted of three excellent short papers by Drs. Curtis, DeJong and Conn.

Dr. A. Curtis discussed the new drug "Sulfanilamide." Dr. R. N. DeJong discussed "Benzedrine"; and Dr. J. W. Conn discussed "Protamine Zinc Insulin."

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**OTOLARYNGOLOGY**—Two Weeks Intensive Course starting April 4, 1938.

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## ◆ General News and Announcements ◆

*The One Hundred Per Cent Club of the  
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1. Ingham County Medical Society
2. Luce County Medical Society
3. Muskegon County Medical Society
4. Shiawassee County Medical Society

These four county medical societies are the first to record 100 per cent paid membership for the year 1938. Dues for 1938 are now payable and are being received daily from the various county medical society secretaries. See your County Secretary today and help your Society become one of the first members of the "One Hundred Per Cent Club for 1938."

*The American College of Surgeons* will hold its 1938 meeting in Detroit, on October 17 to 21.

THE JOURNAL, December issue, contained 108 pages, which included the index to the volume for 1937.

*Dr. Wm. J. Stapleton, Jr.*, and daughter Sally, of Detroit, spent the Christmas vacation in Bermuda.

*The Kent County Medical Society* will hold a Michigan State Medical Society Night on February 9, 1938, in Grand Rapids.

*Dr. Edward Kupka*, formerly of Detroit, is in Oakview, California. Dr. Kupka has gone West with the intention of eventually entering practice.

*Smith, Kline & French*, of Philadelphia, has two pages of advertising in this issue of THE JOURNAL, one in the front section and one in the back section.

*Dr. Andrew P. Biddle*, president of the Detroit Library Commission, has been re-elected to the Commission for a term of six years by the Board of Education of the City of Detroit.

*Dr. J. Duane Miller* of Grand Rapids addressed the Bay County Medical Society on November 24, at the Wenonah Hotel, Bay City. His subject was "The Office Practice of Gynecology."

*Dr. Henry Cook* of Flint, President of the M.S.M.S., visited the Grand Traverse-Leelanau-Benzie County Medical Society on December 7, on the occasion of its Annual Meeting in Traverse City.

*Michigan State Medical Society Night* will be celebrated jointly by the Jackson and Hillsdale County Medical Societies in Jackson on January 18, 1938.

*Wm. J. Burns*, Executive Secretary of the M.S.M.S., addressed the Exchange Club of St. Johns on November 24. His subject was "The Medical Society—A Community Asset."

*Dr. Alfred LaBine* of Houghton has resigned as county physician for Houghton County, his resignation being effective January 1, 1938. The doctor is completing twenty-five years of service in this capacity.

*Exhibit space* for the 1938 Convention of the Michigan State Medical Society is going fast. The 1938 Convention will be held in Detroit at the Book-Cadillac Hotel, September 19, 20, 21, 22 and promises to be a record-breaker.

*Dr. Howard H. Cummings*, Ann Arbor, Councilor of the 14th District, appeared before the Livingston County Medical Society on December 3 at its regular meeting in Howell. His subject was "Obstetrical Problems."

"What the State Society is Doing" was the subject of a talk given by Wm. J. Burns, executive secretary of the State Society, to the Livingston County Medical Society on December 3, 1937, at Howell.

*Dr. Henry Cook*, President of the M.S.M.S., was guest of honor at the meeting of the Alpena County Medical Society in Alpena on December 16, 1937. Doctor Cook was also present at the Annual Meeting of the Bay County Medical Society held on December 15.

*Dr. Kellogg Speed* of Chicago was guest speaker at the joint meeting of the Calhoun, Branch and Hillsdale County Medical Societies held on December 16 at Quincy. Doctor Speed spoke on "Ordinary Fractures and Their Management by the General Practitioner."

*The Advisory Committee on Occupational Diseases* of the M.S.M.S. is composed of: Paul A. Klebba, M.D., Detroit, Chairman; Henry Cook, M.D., Flint; LeMoyne Snyder, M.D., Lansing; Earl G. Krieg, M.D., Detroit; and C. K. Valade, M.D., Detroit.

"Members must remember that every afflicted child case sent in under the Act will never again be a private patient," warns the *Bulletin of the Muskegon County Medical Society*, December, 1937, issue.

At the November 17 meeting of the Muskegon Society, a list of the number of afflicted child cases each man sent in via the Probate Court was read.

*Dr. Harold A. Miller*, of Lansing, was a panel leader in a symposium on home and family relations held December 10 at Eastern High School, Lansing, on the occasion of the Annual Meeting of the School Principals' Association. Doctor Miller discussed the teaching by physicians of social hygiene in public schools.

*Physicians should write now* for hotel reservations in San Francisco if they anticipate attending the 1938 session of the American Medical Association, June 13 to 17. Send your requests to Dr. F. C. Warnshuis, 450 Sutter Street, San Francisco, giving the names of members of your party, type of accommodations desired, rates, date of arrival and departure.

*Dr. L. J. Gariepy* and family, of Detroit, have returned from a two weeks' trip to New Orleans and to Los Angeles, California.

(Continued on page 94)

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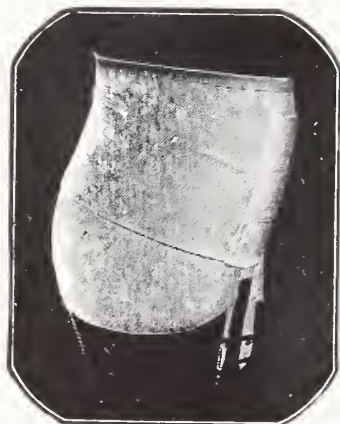
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Application blanks are now available for space in the Scientific Exhibit at the San Francisco Session of the American Medical Association, June 13-17, 1938. The Committee on Scientific Exhibit requires that all applicants fill out the regular forms. Application blanks may be obtained from the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

\* \* \*

Every legal practitioner of medicine in the State of Michigan has been appointed examiner for the purposes of Act 30, Public Acts of 1937, which requires that every person who wishes to register as a student in a barbers' school, must have a certificate from the State Department of Health that he or she is free from contagious and infectious disease. The applicant will present the certificate to the physician.

\* \* \*

An interesting innovation appears in the Muskegon County Medical Society Bulletin under the title "Welcome Doctors."

The biographies of new physicians who start practicing in Muskegon County are printed, and a word of welcome to these new practitioners is extended on behalf of the medical profession of the community.

Great work, members of the Muskegon County Medical Society!

\* \* \*

Dr. Clarence Snyder of Grand Rapids spoke at the "refresher clinic" given at Sturgis, Michigan, on December 13. Doctor Snyder's subject was "Some Interesting Fractures." The "refresher" was arranged under the sponsorship of the Michigan Crippled Children Commission, in coöperation with the Michigan State Medical Society and the Postgraduate Department of the U. of M.

\* \* \*

Mr. James A. Bechtel, executive secretary of the Wayne County Medical Society, and Miss Mary Elizabeth Woods of Detroit, were married on November 25. Following the wedding, the young couple met their numerous friends at a reception at the New Colony Club. Mr. Bechtel succeeded Mr. William J. Burns when the latter was made executive secretary of the Michigan State Medical Society. Mr. Bechtel graduated in law from the Detroit College of Law in May last. The many friends of Mr. and Mrs. Bechtel join in wishing them lifelong happiness.

\* \* \*

Here are a few more of your friends who entered technical exhibits at the Grand Rapids Convention of the Michigan State Medical Society in September, 1937:

Detroit X-Ray Sales Company, Detroit, Mich.  
Dictaphone, Detroit, Mich.  
The Doak Company, Cleveland, O.  
The J. H. Eastman Company, Detroit, Mich.  
The Ediphone Company, Grand Rapids, Mich.  
H. G. Fischer & Company, Chicago, Ill.  
General Electric X-Ray Corporation, Chicago, Ill.  
Gerber Products Company, Fremont, Mich.  
Hack Shoe Company, Detroit, Mich.  
J. F. Hartz Company, Detroit, Mich.

\* \* \*

The Journal of the A.M.A., in its November 20, 1937, issue, made the following editorial comment on an unfortunate sequel of the Elixir of Sulfanilamide publicity:

"Another lamentable feature is the manner in which various businesses involving the use of either diethylene glycol or sulfanilamide are being attacked in uninformed editorials or by whispering

campaigns set afoot by competitors who do not hesitate to profit from unanticipated misfortune. Clearly these deaths resulted from overdosage of a toxic agent wrongly used. Such an incident bears no relationship to the proper uses of either of the substances concerned."

\* \* \*

The Wayne County Medical Society is developing a beautiful exhibit to be displayed at the Detroit and Michigan Exposition, Convention Hall, Detroit, from January 21 to 30, 1938. The exhibit is forty feet long, is developed of black tile, with a silver back wall for charts, has a golden trim, and indirect lighting effect.

Each year, this remarkable exhibit attracts thousands of visitors, who stand in long queues awaiting an opportunity to inspect the numerous charts, displays and specimens designed to bring health information to the public.

\* \* \*

Dr. Henry Cook, Flint, president, Dr. Henry A. Luce, Detroit, president-elect, and Dr. L. Fernald Foster, Bay City, secretary of the Michigan State Medical Society, spoke to the Wayne County Medical Society membership at a meeting arranged in the Art Institute on Monday, December 20. Their general subject was "Brief Activities Affecting the Private Practice of Medicine."

\* \* \*

President Henry Cook announced the reappointment of the Iodized Salt Committee of the M.S.M.S. for the coming year. The members of the committee are as follows: Dr. David M. Cowie, Ann Arbor, Chairman; Dr. Thomas B. Cooley, Detroit; Dr. David J. Levy, Detroit; Dr. Edgar E. Martner, Detroit; Dr. Roy D. McClure, Detroit; and Dr. F. B. Miner, Flint.

Original articles by members of the Michigan State Medical Society appearing in *The Journal of the American Medical Association* recently are:

"The Endocrine Treatment of Menopausal Phenomena," by Jean P. Pratt, M.D., of Detroit, in the December 4th issue.

"Undulant Fever," by S. E. Gould, M.D., Eloise, and I. F. Huddleson, Ph.D., East Lansing, Michigan, in the issue of December 11.

"Exfoliative Dermatitis Following Sulfanilamide," by Gordon B. Myers, M.D., E. C. Vonder Heide, M.D., and Matthew Balcerski, M.D. of Detroit, December 11.

\* \* \*

#### Licensed to Practice

The Michigan State Board of Registration in Medicine held its semi-annual examinations in Lansing, October 13, 14, 15, 1937. The following physicians were given licenses to practice medicine, surgery and midwifery (contingent on the completion of internship, by a few):

Aldrich, Leonard C.....	Northwestern University, 1937
Baef, Michael A.....	University of Moscow, 1910
Belknap, Warren F.....	Loyola University, 1937
Bloemers, Harms W.....	Rush Medical College, 1936
Caughey, Edgar H.....	McGill University, 1937
Dexter, Milton A.....	Tufts Medical School, 1923
Fleming, Dean S.....	University of Minnesota, 1936
Forsyth, James S.....	Northwestern University, 1937
Harper, Harry Penn.....	University of Minnesota, 1936
Hodgkinson, Charles P.....	Temple University, 1936
Hollands, Robert A.....	Rush Medical School, 1936
Knight, John A.....	George Washington University, 1936
Kwedat, Albert T.....	University of Illinois, 1935
Lukas, John Robert.....	Loyola Medical School, 1936
Mathieson, Don R.....	University of Minnesota, 1936
Ostrander, Harold R.....	Rush Medical School, 1935
Sinclair, Sydney E.....	University of Pennsylvania, 1936
Test, Frederick Cleveland...	Northwestern University, 1936
Woodruff, Charles E.....	Yale University, 1926

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## CREDIT IS DUE

The following members of the Michigan State Medical Society were present at the postgraduate assemblies of the Michigan State Medical Society Annual Meeting in Grand Rapids, September 27, 28, 29, 30, 1937:

F. T. Andrews, Kalamazoo; Joseph H. Audries, Detroit; A. L. Arnold, Jr., Owosso.

F. C. Bandy, Sault Ste. Marie; Wyman D. Barrett, Detroit; W. E. Barstow, St. Louis; E. W. Bauer, Hazel Park; Myron G. Becker, Edmore; C. E. Beeman, Grand Rapids; H. M. Best, Lapeer; William L. Bettison, Grand Rapids; Alexander W. Blain, Detroit; Donald R. Brasie, Flint; J. D. Brook, Grand Rapids; A. S. Brunk, Detroit.

A. L. Callery, Port Huron; Alexander M. Campbell, Grand Rapids; Henry R. Carstens, Detroit; A. E. Catherwood, Detroit; L. G. Christian, Lansing; Harry L. Clark, Detroit; Wm. R. Clinton, Detroit; Henry Cook, Flint; Ralph G. Cook, Kalamazoo; Burton R. Corbus, Grand Rapids; H. H. Cummings, Ann Arbor.

L. W. Day, Jonesville; Ray Dean, Three Rivers; Dean C. Denman, Monroe; C. F. DeVries, Lansing; Harry F. Dibble, Detroit; Chas. E. Dutchess, Detroit.

Clifford T. Ekelund, Pontiac; W. C. Ellet, Benton Harbor.

Lynn A. Ferguson, Grand Rapids; Ward S. Ferguson, Grand Rapids; Russell L. Finch, Lansing; S. A. Flaherty, Detroit; Edw. O. Foss, Muskegon; L. Fernald Foster, Bay City.

L. O. Geib, Detroit; S. E. Gould, Detroit; I. W. Greene, Owosso; T. K. Gruber, Eloise.

A. T. Hafford, Albion; Geo. C. Hafford, Albion; T. W. Hammond, Grand Rapids; Harvey C. Hansen, Battle Creek; Robt. B. Harkness, Hastings; Dean W. Hart, St. Johns; L. C. Harvie, Saginaw; Clyde K. Hasley, Detroit; Wilfrid Haughey, Battle Creek; James W. Hawkins, Detroit; T. F. Heavenrich, Port Huron; Louis J. Hirschman, Detroit; Martin H. Hoffman, Eloise; Roy Herbert Holmes, Muskegon; J. A. Hookey, Detroit; R. J. Hubbell, Kalamazoo; A. C. Huebner, Onaway; H. F. Hughes, Hillsdale; Leland E. Holly, Muskegon; Harry G. Huntington, Howell; William A. Hyland, Grand Rapids.

Stanley W. Insley, Detroit.

R. C. Jamieson, Detroit; O. G. Johnson, Mayville.

C. R. Keyport, Graveling; J. Frank Kilroy, Detroit; Paul W. Kniskern, Grand Rapids.

Alfred LaBine, Houghton; F. H. Lashmet, Petoskey; A. I. Laughlin, Clarksville; P. L. Ledwidge, Detroit; W. A. LeMire, Escanaba; E. M. Libby, Iron River; R. W. Lignell, Detroit; Henry A. Luce, Detroit.

Harlen MacMullen, Manistee; \*W. C. McCutcheon, Cassopolis; J. Earl McIntyre, Lansing; W. A. Manthei, Lake Linden; W. S. Martin, Ludington; S. C. Mason, Menominee; F. C. Mayne, Cheboygan; Wilbur C. Medill, Plainwell; W. F. Mertaugh, Sault Ste. Marie; Harold A. Miller, Lansing; V. M. Moore, Grand Rapids; Dean W. Myers, Ann Arbor.

Ellery A. Oakes, Manistee; F. J. O'Donnell, Alpena; James J. O'Meara, Jackson; Mark F. Osterlin, Traverse City.

William H. Parks, Petoskey; Grover C. Penberthy, Detroit; Roy C. Perkins, Bay City; Ralph H. Pino, Detroit; H. W. Plaggemeyer, Detroit; Alton Pullon, Kalamazoo.

Torrance Reed, Grand Rapids; Frank E. Reeder, Flint; Wm. S. Reveno, Detroit; Robert E. Rice, Midland; Phil A. Riley, Jackson; J. M. Robb, Detroit.

Edward Sager, Detroit; Russell F. Salot, Mt. Clemens; Gilbert B. Saltonstall, Charlevoix; Robert D. Scott, Flint; R. Sculley, Grand Rapids; Loren W. Shaffer, Detroit; A. G. Sheets, Eaton Rapids; E. F. Sladek, Traverse City; Richard R. Smith, Grand Rapids; W. Joe Smith, Cadillac; Carl F. Snapp, Grand Rapids; Edward D. Spalding, Detroit; R. A. Springer, Centreville; R. E. Spinks, Newberry; G. Howard Southwick, Grand Rapids; Wm. J. Stapleton, Jr., Detroit; A. F. Stickley, Coopersville; Louis Stern, Detroit; Oscar D. Stryker, Fremont; David I. Sugar, Detroit.

William Torgerson, Grand Rapids; Clarence E. Toshach, Saginaw.

C. E. Umphrey, Detroit; Paul R. Urmston, Bay City; C. K. Valade, Detroit; V. H. Vandevanter, Ishpeming; B. H. Van Leuven, Petoskey.

R. L. Wade, Coldwater; A. V. Wenger, Grand Rapids; John A. Wessinger, Ann Arbor.

Gordon W. Yeo, Big Rapids.

*The above list represents the registration of Monday, September 27, 1937. The registration of Tuesday, Wednesday, and Thursday will be published in succeeding issues of the JOURNAL.*

\*Died October 1, 1937.

*Crippled and Afflicted Child Commitments* for the month of November, 1937, were as follows: Crippled Child: Total of 250, of which 117 went to University Hospital, and 133 went to miscellaneous hospitals.

Of the above, Wayne County sent 29 to hospitals, of which one went to University Hospital, and 28 went to miscellaneous hospitals.

Afflicted Child: Total of 1,054 cases, of which 181 went to University Hospital, and 873 went to miscellaneous hospitals.

Of the above, Wayne County sent 277 to hospitals, of which 14 went to University Hospital, and 263 went to miscellaneous hospitals.

The above figures represent a further drop of 184 cases of crippled and afflicted children for the month of November over the month of October.

\* \* \*

*The Washtenaw County Medical Society* sent a special letter to its membership relative to the filter system, which has been functioning in that county for eighteen months, passing on all afflicted and crippled children receiving medical aid from the state. Approximately fifty members of the society have given freely of their time during this period.

The time of service is now for four successive Tuesday mornings, from nine to eleven o'clock. All applicants are examined by the medical filter committee in the Ann Arbor High School; a member of the Probate Court Staff serves as secretary.

The work of medical filter committees, such as Washtenaw's, has resulted in the reduction of the load of state cases. Much credit is due the medical profession for this work, throughout the state.

\* \* \*

*Under the Afflicted Child Law*, Wayne County physicians may now elect to charge a private fee for their medical service to the patient, with the State paying for hospitalization, due to an arrangement recently made with Probate Judge D. J. Healy, Jr., Representatives of the Crippled Children Commission and of the Auditor General's office. The physician must signify his intention to the administrators of the Act.

This program is still in the experimental stage. It will aid the private-physician-relationship and go a long way toward re-establishing a public sense of values for medical services and an attitude of self-reliance in many American families.

Similar programs might be tried in other localities of the state through coöperative arrangements between the county medical society, the Probate Judge, the filter committees, the Auditor General of the state, and the Michigan Crippled Children Commission.

\* \* \*

*The Narcotic Committee* of the Wayne County Medical Society has collaborated with the Detroit Bureau of Governmental Research, Inc., in a study of "narcotic addiction as a factor in petty larceny in Detroit."

This study of narcotic addiction as a factor in predatory crime, particularly petty larceny, brings out information concerning the number of addicts, the character, extent and cost of their drug consumption, and the nature and amounts of their thieving, and recommendations for curtailing the resulting loss to Detroit merchants and others. The total value of merchandise stolen from Detroit merchants is estimated in the report as \$5,475,000. The report has been printed and is available as "School of Public Affairs and Social Work of Wayne University, Report No. 9," and may be ob-

(Continued on page 98)

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3,000 dispensing envelopes \$6.00. 1,000 Statements and 1,000 letterheads, each 8½x11, Hammermill Bond \$3.50. 3,000 labels \$5.50. All three \$14.00. Alexander Printing Company, Ada, Ohio.

**MORPHINE AND OTHER DRUG ADDICTIONS**—Institutional care and treatment of selected patients who have responsibilities, wish to make good and learn how to keep well; methods easy, regular, humane. Twenty-eight years' experience. Dr. Weirick's Sanitarium, Elgin, Ill.

(Continued from page 96)

tained from the Detroit Bureau of Governmental Research, 5135 Cass Avenue, Detroit.

\* \* \*

### American Board of Obstetrics and Gynecology

The next examination (written and review of case histories) for Group B candidates who have filed applications will be held in various cities of the United States and Canada, on Saturday, February 5, 1938.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, California, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Applications for admission to the June, 1938, Group A examinations must be on an official application form and filed in the Secretary's Office before April 1, 1938.

For further information and application blanks address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pa.

\* \* \*

*Nine per cent sales tax?* Taxpayers are paying approximately \$105,000,000 this year to the State of Michigan—not to mention the \$118,000,000 to \$125,000,000 they are paying to the county, city and township governments of this state.

Saddle on the taxpayer a complete system of "Free" medicine for all the 4,830,000 people of this state, and you will increase taxes by \$176,295,000 (based on the estimate of a proponent, Mr. Bower Aly, who stated: "A program of complete medical care available to every person would actually cost only ten cents per day per person."—In the radio debate on State Medicine, November 12, 1935).

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Add to this cash payments for lost work days due to illness, including feigned illness, and your Sales Tax becomes 15 per cent instead of the present 3 per cent!

Shall the back of the taxpayer be broken?

\* \* \*

*The Michigan Child Guidance Institute* was created by an act of the 1937 Legislature (P. A. 285 of 1937). Its purpose is to inquire into the causes of child delinquency, of improving methods of treatment in cases of delinquents, neglected and defective children and/or coordinating the work of public and private agencies in examining and caring for such children.

The Institute is attempting to fulfill its purpose by a program of coöperation with physicians, parents, the schools, Probate Courts, established social agencies and others in the community.

The Institute will not extend medical and psychiatric treatment to cases examined by it, but will regard treatment as specifically the function of local physicians or local institutions.

L. J. Carr, Director of the Institute, which is located in Ann Arbor and is under the control of the Regents of University of Michigan, informed the Michigan State Medical Society on December 9: "The Institute proposes to work through the local medical society. We shall not do treatment ourselves."

Any responsible person may refer to the Institute for examination any child who is known to be likely to develop serious mental, moral or personality defects. Address Michigan Child Guidance Institute, University of Michigan, Ann Arbor, Mich.

## IN MEMORIAM

## Dr. Carl Bonning

Dr. Carl Bonning of Detroit died on December 23, 1937. Dr. Bonning was born in Germany in 1855. He came to this country in 1872 and became a retail druggist. In 1879 he returned to Germany to study medicine at the Universities of Marburg and Strasburg and was graduated in 1882; he came to Detroit the following year. Dr. Bonning was in general practice for thirty years. He was president of the Detroit Medical and Library Association in 1900 when it merged with the Wayne County Medical Society, of which he was made an honorary member. He was also an honorary member of the Michigan State Medical Society. Dr. Bonning is survived by his wife, Mrs. Hermine Kiefer Bonning, sister of the founder of Herman Kiefer Hospital, and two daughters, Mrs. Richard H. Marr and Miss Hertha F. Bonning.

## Dr. E. M. Houghton

Dr. E. M. Houghton of Detroit died at his home on Longfellow Avenue, Detroit, on December 14, at the age of seventy years. Dr. Houghton was for many years director of the medical and research laboratories of Parke, Davis & Co., a position from which he retired in 1929. Dr. Houghton became ill last June while traveling in Italy and returned to the United States. He attended the University of Michigan from which he was graduated in 1893, with the degree of pharmaceutical chemist, and two years later he received his M.D. degree from the University. Dr. Houghton joined the Parke, Davis staff in 1895. From 1897 to 1902 he was lecturer in Pharmacology in the Detroit College of Medicine and Surgery and special lecturer at the University of Michigan for several years following. Dr. Houghton was a member of many scientific associations, including the Wayne County Medical Society, the Michigan State Medical Society, the American Medical Association, The American Pharmaceutical Association, the American Society of Bacteriologists, American Society of Immunologists, National Tuberculosis Association and the American Physiological Association.

In 1892 Dr. Houghton married Jennie Hunt, who died in 1935. Three children from this marriage were Mrs. William C. Allee of Birmingham, Michigan, Mrs. Edward C. Boss of Huntington Woods, and Ralph H. Houghton of Detroit. Last April, Dr. Houghton married Alice Maude Whitehead. He also leaves a brother, Roy A. Houghton, of Elbow, Saskatchewan.

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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**MANUAL OF CLINICAL AND LABORATORY TECHNIC.** By Hiram B. Weiss, A.B., M.D., F.A.C.P., Associate Professor of Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio; and Raphael Isaacs, A.M., M.D., F.A.C.P., Associate Professor of Medicine, Assistant Director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan, Ann Arbor, Mich. Fifth Edition. Reset. 141 pages. Cloth, \$1.50 net. Philadelphia and London: W. B. Saunders Company, 1937.

**A PRIMER FOR DIABETIC PATIENTS.** An outline of Treatment for Diabetes with Diet, Insulin and Pro-tamine Zinc Insulin, including directions and charts for the use of physicians in planning diet prescriptions. By Russell M. Wilder, M.D., Ph.D., F.A.C.P., Professor and Chief of the Department of Medicine of the Mayo Foundation, University of Minnesota; Head of Section on General Metabolism, Division of Medicine, The Mayo Clinic. Sixth Edition, Reset. 191 pages. Philadelphia and London: W. B. Saunders Company, 1937. Cloth, \$1.75 net.

**PHYSIOLOGY FOR PHARMACEUTICAL STUDENTS.** By Harold Hayden Barber, B.Sc., Ph.D., F.I.C., head of the Sub-department of Physiology in the University College of Nottingham. Baltimore, Wm. Wood and Company, 1937. Price, \$4.50.

**PHYSIOLOGY FOR PHARMACEUTICAL STUDENTS.** By Harold Hayden Barber, B.Sc., Ph.D., F.I.C. Head of the Sub-department of Physiology in the University College of Nottingham. Baltimore: William Wood and Company, 1937.

This book was written specifically for students of pharmacy, and is an elementary text covering the fundamentals of physiology. For those for whom it is especially designed, it should fill a need.

**PRACTICAL PROCTOLOGY.** By Louis A. Buie, A.B., M.D., F.A.C.S., Head of Section on Proctology, The Mayo Clinic; Professor of Proctology, The Mayo Clinic; Professor of Proctology, the Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. 512 pages with 152 illustrations. Philadelphia and London: W. B. Saunders Company, 1937. Cloth, \$6.50 net.

In his foreword to this book, Dr. Charles H. Mayo writes, "Dr. Buie has presented the old and the new in a most interesting and fascinating manner." The work is the result largely of the author's long experience as proctologist of the Mayo Clinic.

**MODERN TREATMENT IN GENERAL PRACTICE,** Volume III, edited by Cecil P. G. Wakeley, D.Sc., F.R.C.S., F.R.S.E., Fellow of King's College, London, Senior Surgeon, King's College Hospital, Editor of "The Medical Press and Circular." Baltimore, Wm. Wood and Company, 1937.

This is a work of multiple authorship—a work by British internists and surgeons, written for the most part with great clarity. A great many subjects are included, but, as the title assumes, it is a work for the general practitioner, not the specialist.

**ORTHODIASCOPY:** An Analysis of over Seventeen Hundred Orthodiascopic Examinations. By Chester M. Kurtz, M.D., F.A.C.P., Assistant Professor of Medicine, University of Wisconsin, Cardiologist to the State of Wisconsin General Hospital. Price \$3.50. New York: The Macmillan Company, Publishers, 1937.

Any actual heart lesion may be expected to be followed by changes in contour and size of some

part of the organ. Orthodiascopy is therefore a method of studying the heart lesion by observing any effect it may have produced in the heart muscle; in other words, the walls of the heart. It is in reality a radiographic and fluoroscopic study of the heart. It should be given a place alongside of that other method of heart study, namely, electrocardiography. As intimated, the author's work is based on a study of 1,700 examinations of the heart by the orthodiascopic method. The new work will appeal chiefly to those apart from cardiologists who are equipped to use it.

**BIOLOGICAL AND CLINICAL CHEMISTRY.** By Matthew Steel, Ph.D., Professor of Biochemistry in the Long Island College of Medicine, Brooklyn, N. Y. 770 pages. Lea & Febiger, Phila., 1937.

Unlike conventional textbooks in biochemistry, this work is characterized by the presentation of biochemical principles, normal and pathological metabolic chemistry and clinical tests. The author points out that increased knowledge of metabolic diseases has justified a somewhat different approach to biochemistry. Whether or not this will be acceptable to teachers of biochemistry remains to be shown, but, at any rate, the practicing physician is provided in the present text with a nicely coordinated and practical work on the chemical side of medicine. The subjects covered are the chemistry of carbohydrates, lipides and proteins, the physical chemistry and biophysics of cells, vitamins, hormones and catalysts, characteristics of blood, the chemistry and metabolism and features of pathological metabolism.

**A METHOD OF ANATOMY,** Descriptive and Deductive—By J. C. Boileau Grant, M.C., M.B., Ch.B., F.R.C.S. (Edin.), Professor of Anatomy in the University of Toronto. Wm. Wood and Company, 1937. Price—\$6.00.

Anatomy to a great many medical students is the most difficult subject of the medical curriculum. It comes in the first year of their course and is usually a matter of sheer memory, so that the student with the best memory, as a rule, passes with the highest grade. The method of study presented in this volume is that of correlating anatomical facts and studying them in their mutual relationships. The student learns to reason anatomically. Osteology is therefore not presented as a subject apart, but is considered in relation to the surrounding soft structures. Viscera are considered by reference to comparative anatomy and to embryology. The principles are illustrated throughout by line drawings designed to show structural relations and to illustrate function. The work is a distinct contribution, not only to anatomical teaching, but to the study of anatomy by the physician and surgeon who would review the subject.

**CRIPPLED CHILDREN, THEIR TREATMENT AND ORTHOPEDIC NURSING.** By Earl D. McBride, B.S., M.D., F.A.C.S. Assistant Professor of Orthopedic Surgery, University of Oklahoma, School of Medicine. Second Edition. St. Louis: The C. V. Mosby Company, 1937.

This book is written, primarily, to instruct the nurse in the orthopedic details she should learn while in training and to serve her for reference and guide in the field of orthopedic nursing. Through the knowledge to be gained here the social worker should be able to recognize remediable conditions earlier than she otherwise would. The book is well written and well illustrated and should be a valuable work for those for whom it is intended.

## Among Our Contributors

**Dr. N. E. Aronstam** is a graduate of Michigan College of Medicine in 1898, where he taught dermatology from 1904 to 1907. He limits his practice to dermatology and syphilology.

\* \* \*

**Dr. Clark D. Brooks** was graduated from the Detroit College of Medicine in 1905. He is chief of the surgical staff of Harper Hospital, Detroit, and Associate Professor of Surgery at the Wayne University College of Medicine. Dr. Brooks is a Fellow of the American College of Surgery.

\* \* \*

**Dr. Alexander M. Campbell** is a graduate of the Wayne University College of Medicine. He is chairman of the Committee on Maternal Health, Michigan State Medical Society; Consulting Obstetrician United States Public Health Service; chairman Advisory Committee on State, Maternal and Child Health Service; member of the American Gynecological Society, American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Chicago Gynecological Society, and Detroit Obstetrical and Gynecological Society.

\* \* \*

**Dr. Wilfrid T. Dempster** is a graduate of the University of Michigan, having obtained the degree of B.S. in 1926, M.A. in 1927 and Sc.D. in 1929. Since 1929 he has been instructor in the department of anatomy in the University of Michigan Medical School.

\* \* \*

**Dr. Harry M. Nelson** was graduated from the University of Michigan in 1920. He is a Fellow of the American College of Surgeons, member of the American Board of Obstetrics and Gynecology, Chief Gynecologist and Senior Attending Obstetrician and director of the Tumor Clinic at Woman's Hospital. Dr. Nelson is also Assistant Professor in Gynecology at the Wayne University College of Medicine.

**Dr. A. E. Schiller** was graduated from the Detroit College of Medicine and Surgery, now the Medical Department of Wayne University, in 1914. He limits his practice to dermatology. He has been attending dermatologist to Grace Hospital, Detroit, from 1925 to the present time.

\* \* \*

**Dr. Carl F. Shelton** was graduated from the Medical College of Virginia in 1930. He is on the attending staff of Woman's Hospital in the Department of Gynecology and Outpatient service.

\* \* \*

**Dr. Roger S. Siddall** was graduated M.D. from Johns Hopkins University in 1920. He is Assistant Surgeon, Department of Obstetrics and Gynecology at Harper Hospital, Detroit, and he is on the consultant staff of Herman Kiefer Hospital, Detroit. Dr. Siddall is Assistant Clinical Professor of Obstetrics and Gynecology, Wayne University College of Medicine, and extramural lecturer in Postgraduate Medicine, University of Michigan.

\* \* \*

**Dr. Clarence H. Snyder** was graduated from the University of Michigan, receiving his M.D. in 1924. He received his M.S. (Surgery) from the University of Michigan in 1934. He is a member of the Michigan State and Michigan Orthopedic Societies. He is a Fellow of the American Academy of Orthopedic Surgeons and a Diplomate of the American Board of Orthopedic Surgery.

JANUARY, 1938

## THE BUSINESS SIDE OF MEDICINE

(Continued from page 68)

hour at noon in which to relax, or is she so overworked that cheerfulness and efficiency are next to impossible?

Many a doctor criticises his office assistant for not taking enough responsibility, for taking too much responsibility, for not keeping busy, for being out when he wants her, for not handling patients smoothly, for not getting correct names and addresses on accounts, for a poor telephone voice, and for one hundred and one other things, when much of the real fault is his own for not having taken time to correct her faults and teach her her duties. In many cases the doctor's ideal office girl would have to be a nurse, dietitian, laboratory technician, stenographer, bookkeeper, filing expert, and a personality plus receptionist all rolled into one. If your office girl does not meet your requirements, instead of immediately looking around for another why not list the things that could be improved and then one by one correct them by careful training? It is doubtful if there is any position that offers more possibilities for the development and use of ability in so many varying lines than does that of a doctor's office assistant, and yet there is no training school that can give all of the instruction and experience that are necessary to perfect a girl in such a many sided job. Time spent in patiently training an assistant who best suits your needs will pay dividends not only in increased practice and improved collections, but also in the personal satisfaction of having a smooth-running office.

### Eleven Ages of Man

- First—Milk
- Second—Milk and Bread
- Third—Milk, bread and spinach
- Fourth—Oatmeal, bread and butter
- Fifth—Ice cream soda and hot dogs
- Sixth—Minute steak, fried potatoes, coffee and apple pie
- Seventh—Bouillion, roast duck, escalloped potatoes, creamed broccoli, fruit salad, divinity fudge, demi-tasse.
- Eighth—Pate-de-foie-gras, weiner-schnitzel, potatoes, Parisian egg plant, a-Yopers, demi-tasse and Roquefort cheese.
- Ninth—Two soft poached eggs, toast and milk
- Tenth—Crackers and milk
- Eleventh—Milk.



## COUNTY SOCIETIES

## BRANCHES OF THE MICHIGAN STATE MEDICAL SOCIETY

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING	
			Regular	Annual
Allegan .....	G. H. RIGTERINK Hamilton	M. B. BECKETT Allegan	1st Tuesday	1st Tuesday December
Alpena-Alcona- Presque Isle.....	C. A. CARPENTER Onaway	HAROLD KESSLER Alpena	Last Thursday 6:00 p. m.	Last Thursday December
Barry .....	H. S. WEDEL Freeport	G. F. FISHER Hastings	2nd Thursday 8:00 p. m.	1st Thursday January
Bay-Arenac-Iosco- Gladwin .....	C. L. HESS Bay City	A. L. ZILIAK Bay City	2nd and 4th Wednesday (ex- cept July, Aug., Sept.) 6:00 p. m.	2nd Wednesday December
Berrien .....	HARRY KOK Benton Harbor	A. F. BLIESMER St. Joseph	2nd Wednesday or Thursday	2nd Wednesday or Thursday, December
Branch .....	BERT W. CULVER Coldwater	F. S. LEEDER Coldwater	3rd Thursday 6:30 p. m.	3rd Thursday December
Calhoun .....	J. E. ROSENFELD Battle Creek	WILFRID HAUGHEY Battle Creek	1st Tuesday (except July and Aug.)	1st Tuesday December
Cass .....	S. E. BRYANT Dowagiac	K. C. PIERCE Dowagiac	2nd Wednesday or Thursday	December 15
Chippewa- Mackinac .....	J. F. DARBY St. Ignace	DWIGHT F. SCOTT Sault Ste. Marie	1st Friday	1st Friday December
Clinton .....	F. E. LUTON St. Johns	T. Y. HO St. Johns	Last Tuesday (Oct. to June, incl.)	Last Tuesday October
Delta .....	W. A. LEMIRE Escanaba	G. W. BENSON Escanaba	1st Thursday 8:30 p. m.	December 2
Dickinson-Iron .....	L. E. IRVINE Iron River	W. H. HURON Iron Mountain	1st Thursday 6:30 p. m.	1st Thursday December
Eaton .....	H. A. MOYER Charlotte	THOMAS WILENSKY Eaton Rapids	Last Thursday	No set date
Genesee .....	A. McARTHUR Flint	C. W. COLWELL Flint	2nd and 4th Tuesday (ex- cept July and August)	2nd Tuesday November
Gogebic .....	C. C. URQUHART Ironwood	F. L. S. REYNOLDS Ironwood	3rd Tuesday	3rd Tuesday December
Grand Traverse- Leelanau-Benzie	MARK OSTERLIN Traverse City	C. E. LEMEN Traverse City	1st Tuesday 8:00 p. m.	1st Tuesday December
Gratiot-Isabella- Clare .....	KENNETH P. WOLFE Breckenridge	RICHARD L. WAGGONER St. Louis	3rd Thursday	3rd Thursday December
Hillsdale .....	W. E. ALLEGER Pittsford	E. G. McGAVRAN Hillsdale	Last Thursday	Last Thursday December
Houghton-Baraga- Keweenaw .....	L. E. COFFIN Painesdale	C. A. COOPER Hancock	1st Tuesday	1st Tuesday January
Huron-Sanilac .....	F. O. KIRKER Sandusky	E. W. BLANCHARD Deckerville	2nd Thursday	2nd Thursday December
Ingham .....	DANA M. SNELL Lansing	R. J. HIMMELBERGER Lansing	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Ionia-Montcalm .....	L. E. KELSEY Lakeview	JOHN J. McCANN Ionia	2nd Tuesday 7:00 p. m.	2nd Tuesday December
Jackson .....	JOHN VAN SCHOICK Hanover	H. W. PORTER Jackson	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kalamazoo- Van Buren .....	W. G. HOEBEKE Kalamazoo	L. W. GERSTNER Kalamazoo	3rd Tuesday 7:30 p. m.	3rd Tuesday December
Kent .....	A. J. BAKER Grand Rapids	J. M. WHALEN Grand Rapids	2nd and 4th Wednesday 8:15 p. m.	2nd Wednesday December
Lapeer .....	G. C. BISHOP Almont	C. C. JACKSON Imlay City	2nd Thursday	December or January
Lenawee .....	A. W. CHASE Adrian	ESLI T. MORDEN Adrian	3rd Tuesday	3rd Tuesday December
Livingston .....	BERNARD H. GLENN Fowlerville	DUNCAN C. STEPHENS Howell	1st Friday 6:30 p. m.	1st Friday December
Luce .....	A. T. REHN Newberry	C. D. HART Newberry	1st Tuesday 8:00 p. m.	1st Tuesday December
Macomb .....	JOSEPH N. SCHER Mt. Clemens	R. F. SALOT Mt. Clemens	1st Monday 12:00 noon	1st Monday December
Manistee .....	KATHRYN BRYAN Manistee	C. L. GRANT Manistee	Every Monday noon	3rd Thursday January
Marquette-Alger .....	E. R. ELZINGA Marquette	D. P. HORNBOKEN Marquette	No set date	December
Mason .....	W. S. MARTIN Ludington	CHAS A. PAUKSTIS Ludington	No set time	No set time
Mecosta-Osceola .....	THOMAS P. TREYNOR Big Rapids	GLENN GRIEVE Big Rapids	2nd Tuesday	2nd Tuesday December

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#### AN OUTLINE OF LIVER FUNCTIONS AND JAUNDICE\*

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Jaundice is a symptom which may be extra- or intrahepatic in origin. It is a symptom of *vital importance* only when it is associated with hepatic insufficiency. The seriousness of jaundice depends either on the extent to which the vital function of the liver is impaired or the extent to which the cause of the jaundice may in time lead to hepatic insufficiency.

The liver manifests many activities. The importance of the liver cannot be appreciated until one views and comprehends its many important and diverse activities. Considering its many activities, its large factor of safety and regenerative capacity, one is not surprised that an adequate function test has not been devised. The tests of function are now directed toward ascertaining the extent of certain individual activities of the liver. If the liver possessed *a single* vital function, which is not likely, and if that function were known, then a single functional test might be devised. Until we find out why a hepatectomized dog dies in from twelve to forty-eight hours, we shall be working more or less in the dark insofar as adequate tests of the vital functions of the liver are concerned.

The activities of the liver may be outlined very briefly as follows:

1. *The liver stores food materials.*

- a. Carbohydrate in the form of glycogen or animal starch.

In fasting, the store lasts for only twelve to twenty-four hours.

- b. Protein is stored, but probably as liver protein and not as a special protein.

The liver of rats during a two-day fast loses 20 per cent of its original protein; other organs only 4 per cent. In a more prolonged fast, liver may lose 40 per cent of its protein.

- c. Fat. On a well-balanced diet liver fat is fairly constant, 2 to 4 per cent (dogs); 40 to 70 per cent is neutral fat; the remainder is phospholipins. Liver fat is increased by a fatty diet, and the liver may become 50 per cent fat. When the glycogen content of liver decreases, the fat content usually increases. Thus, on fasting, liver fat increases, if fat is present in the fat depots.

Fat content of liver is increased by chloroform, phosphorus and carbon tetrachloride, and the glycogen is decreased.

Alcohol speeds fat deposition in liver in the presence of a high fat diet. Fat accumulates in the liver in deficiency of pancreatic juice.

Feeding pancreas or choline prevents and reverses the fatty infiltration due

\*Read before the Wayne County Medical Society, November 15, 1937.



- to a pancreatic deficiency, fatty diet, or cholesterol feeding.
- d. The liver stores the anti P. A. factor, the substance important (anti-secondary anemia factor) for building hemoglobin, and Vitamins A and D. It is rich in Vitamin B and G and stores Fe and Cu.
2. *The liver manufactures food materials.*  
Glucose is the sugar of choice of the body cells. Some levulose and but little galactose can be oxidized by body cells.
    - a. Liver converts glucose, levulose and galactose to glycogen and then, as needed, the glycogen is changed to glucose. Galactose is not a good glycogen former.  
Lactic acid is converted to glycogen in liver.  
Liver maintains blood sugar level.
    - b. Forms glucose from certain amino acids.
    - c. May make fat from glucose, protein and glycerol.
    - d. Synthesizes certain amino acids.
    - e. Probably desaturates fatty acids.
    - f. Makes various organic acids, which may be oxidized or used for synthesis and which result from deamination of proteins.
    - g. Makes Vitamin A from carotene.
    - h. Ketone bodies. One theory regards them as foods.
  3. *Other substances manufactured by the liver.*
    - a. Blood fibrinogen and heparin, or antiprophthrombin. R. B. cells are formed in embryo.
    - b. Ketone bodies; glucose retards or prevents their formation.
    - c. Bile salts; makes and also destroys.
    - d. Cholesterol, possibly; at least liver is concerned in cholesterol metabolism.
    - e. Urea, from ammonia, which arises chiefly from deamination of proteins.
    - f. Uric acid, possibly; liver may destroy it also.
    - g. Next to muscle, liver is an important source of body heat.
    - h. Changes urobilinogen (urobilin is oxidized urobilinogen), which is produced normally in, and absorbed from the intestine, to bilirubin.
  - i. Forms some bile pigment or bilirubin from hemoglobin.
  - j. Blood albumin and globulin.
  - k. Glucuronic acid conjugation products.
  - l. Produces histamine in anaphylactic shock.
  - m. Very probably produces antibodies.
4. *Detoxication.*
    - A. By chemical means:
      1. Conjugation of toxic substance with:
        - (a) sulphuric acid, e.g. indoxyl sulphate,
        - (b) glucuronic acid, e.g. phenol, benzoic acid, menthol, etc., form glucuronides,
        - (c) glycine, e.g. benzoic acid plus glycine yields hippuric acid.
      2. (a) by oxidation,  
(b) reduction,  
(c) methylation,  
(d) acetylation.
    - B. By excretion in bile:
      - (a) heavy metal such as Hg,
      - (b) certain drugs,
      - (c) bacteria.
    - C. By storage in liver cells:
      - (a) strychnine, e.g., as in the chicken,
      - (b) dog's liver can destroy strychnine.
    - D. By reticulo-endothelial activity:
      - (a) removes bacteria, foreign protein, dyes, etc., from the blood stream. In Eck fistula dogs, or dogs with a chronic hepatic insufficiency, a meat ration causes a syndrome called "meat intoxication." Such animals do better on a high carbohydrate diet. They also do better if a source of glucuronic acid, chondroitin, is fed.
  5. *Blood volume regulation:*
    - a. Serves as a reservoir for red blood cells and fluid,
    - b. Tends to prevent blood dilution after drinking water, and serves as a

- c. "Flood chamber" to prevent over-distention of right heart.
- d. Some claim that the liver is important in maintaining the normal ionic equilibrium of the blood.

6. *Excretory substances in bile:*

Bile pigment  
Bile salts  
Fatty acids  
Alkali  
Cholesterol  
Phospholipins  
Calcium  
Certain dyes, drugs (cinchophen, salicylic acid, Hg.)

Many texts include lecithin as a constituent of bile; recent studies show that lecithin or neutral fat is not present in bile to a significant extent.

7. *Liver is related to the glands of internal secretion.*

- a. Islets of Langerhans of pancreas.  
Diabetic liver practically glycogen-free. Insulin causes the diabetic liver to deposit glycogen.
- b. Epinephrine decreases glycogen in the liver.
- c. Removal of hypophysis or adrenals prevents or ameliorates glycosuria and hyperglycemia due to extirpation of the pancreas. This probably means that the removal of the hypophysis and adrenals reduces sugar formation by the liver.
- d. An extract of the anterior lobe causes ketosis probably by acting on the liver.
- e. A low glycogen reserve exists in the liver in hyperthyroidism.
- f. Liver insufficiency may cause infertility. A female Eck fistula dog has never produced young.

The foregoing outline enumerates the better known activities of the liver. Certain other well known facts pertaining to the physiology of the liver will now be mentioned.

8. *Factors of safety and regeneration of liver cells.*

Only 20 per cent of the normal liver may maintain its normal functions. The capacity of the liver to regenerate is remarkable. On

removal of 70 per cent of the liver in rats and dogs, 90 per cent regeneration will occur in a few weeks.

Restriction of portal blood supply, obstruction of a bile duct, or cirrhosis of the liver prevents or retards regeneration. Regeneration can occur, however, in a liver in which cirrhosis is progressing due to the administration of carbon tetrachloride. The regenerated liver cells are under certain conditions known to be more resistant to the poison which caused the necrosis.

The tremendous factor of safety in the liver means that at least 70 or 80 per cent of the hepatic cells must be impaired to give a positive liver function test.

9. *Effects of extirpation of the liver.*

- a. Death results in from twelve to eighteen hours.
- b. Hypoglycemia occurs, and glucose administration prolongs life up to twenty-four to forty-eight hours, but the dog dies with blood laden with glucose.
- c. Rise in bilirubin in the blood occurs, because it cannot be excreted by the liver.
- d. Urea falls to almost zero.
- e. Amino acids increase in blood.
- f. Uric acid increases.

Actual cause of death is unknown. Is it due to the loss of some single vital function? Or, is it due to the loss of the multifold activities of the liver?

**White Bile**

When the surgeon opens the common duct he sometimes finds what he calls "white bile." This raises the questions: under what conditions is white bile found? And, what is its source?

White or lightly pigmented bile is found in the bile ducts under the following conditions:

- A. An obstructed common bile duct.
  - (a) With the gall bladder removed
  - (b) With a functionless gall bladder in place, or
  - (c) In long standing obstruction due to carcinoma, or from pressure on extrahepatic ducts by abdominal tumors; and



B. In severe toxic or infectious hepatitis.

The "white bile" is chiefly a secretion of the epithelium of the ducts.

The presence of "white bile" in the ducts always denotes the presence of hepatic injury. Such patients would be more susceptible to an anesthetic, and to trauma, and to the development of a serious hepatitis.

"White bile" or "hydrops fluid" is found in the gall bladder in the presence of cystic duct occlusion and in the absence of infection of the gall bladder.

### Jaundice

Jaundice is the term used to designate a yellowness of the skin, sclera and secretions due to excessive bilirubin in the blood. Jaundice or icterus must be distinguished from yellowness due to carotenemia or picric acid ingestion.

The blood of man normally contains from 0.1 to 0.25 mg. of bilirubin per 100 c.c. The renal threshold for bilirubin in man is about 2 mg. per 100 c.c., that is, bilirubin does not appear in the urine until the concentration in the blood is 2 or more mg. per 100 c.c. of blood.

In obstructive jaundice if 2 mg. per 100 c.c. of bilirubin are present in the blood for several days, jaundice or visible icterus occurs, and bile pigment appears in the urine. In hemolytic jaundice the bilirubin content of the blood must be higher than 2 mg. before the patient becomes jaundiced or bile pigment appears in the urine. The explanation offered for this observation is that in hemolytic jaundice the pigment is bound to protein, or some other substance, so that it does not readily pass from the blood into the tissues.

The most simple view of the various causes of jaundice, I believe, is that jaundice is due to a disturbance:

A. *Before the liver*—Hemolytic jaundice, hereditary and symptomatic (e.g., infectious diseases, pernicious anemia, etc.).

B. *In the liver*—Toxic and infectious hepatitis and cirrhosis. Hepatocellular jaundice; or intrahepatic jaundice.

C. *After the liver*—Obstructive jaundice, mechanical or inflammatory.

In hemolytic jaundice, bilirubin is made beyond the capacity of the liver to excrete it. If the secretory activity of the liver is

depressed in hemolytic jaundice, such has not been proven to exist. *Bile is formed and stools are heavily pigmented.* Icterus neonatorum is the best example. Familial jaundice is another example. In symptomatic jaundice, the causative agent sometimes affects the liver and then complicates the jaundice.

In toxic and infectious hepatitis and cirrhosis, the liver cannot remove bile pigment from the blood at a normal rate. The bile may be *normally pigmented (cirrhosis)*, or only lightly pigmented, depending on the degree of hepatic insufficiency.

In obstructive jaundice the obstruction does not have to be complete to produce jaundice. The secretory pressure of bile is about 30 cm. of water; but 20 to 25 cm. of water pressure in the common bile duct is adequate for the production of hyperbilirubinemia.

The obstruction may be due mechanically to a carcinoma of the pancreas or the ampulla of Vater, in which case the obstruction is usually complete and the jaundice grows progressively worse. It may be due to a ball-valve type of obstruction by a stone, in which case it may be intermittent. Courvoisier's law is helpful for the differential, but it holds for only about one-half of the cases; some say less, others more. A stone, of course, is more likely to cause colic. Obstruction, producing jaundice, may also be due to an inflammation of the ampulla or of the common and hepatic ducts (catarrhal jaundice). In catarrhal jaundice, however, hepatitis is frequently present and complicates the diagnosis.

In the differential diagnosis of jaundice the experience of the clinician and the history, associated symptoms and physical findings are of prime importance. There is no laboratory short-cut; a carefully taken and detailed history is very important. The laboratory aids give some idea of the hepatic damage, and, if properly interpreted, are of assistance in differential diagnosis. As will be seen from the table to follow, the results of laboratory tests do not *per se* differentiate between a medical and surgical jaundice due to obstruction of the ducts or a hepatitis. In the presence of complete obstruction of the common duct the differentiation is not so difficult (accuracy in the hands of a skilled physician is 80 per cent),

TABLE I

Acute and Subacute Intrahepatic Jaundice 12 Cases	Chronic Intrahepatic Jaundice 2 Cases	Obstructive Jaundice —16 Cases— Duration 2 wks.—7 1/2 mo.
7+ galactose	galactose — in both cases	galactose
5- (jaundice subsiding) Urobilinogen present in all cases	urobilinogen present in both cases	urobilinogen absent from urine in all completely obstructive cases

but, when the obstruction of the duct is incomplete, the differential diagnosis is very difficult.

*Galactose tolerance test* (40 gm. are given with water on an empty stomach; urine is collected for five hours. Three gm. or more in the urine indicates acute hepatitis.)

Advantages:

- Rapidly absorbed.
- Utilized only by the liver.
- Low kidney threshold, if any.

In severe hepatic injury the liver cannot convert galactose adequately into glycogen, so an excess appears in the urine.

The test is positive (3 gm. or more in the urine) in 80 per cent of cases with acute hepatitis; positive in only 6 to 10 per cent of cases of obstructive jaundice.

*In acute hepatitis a negative result is obtained if the performance of the test is delayed until regeneration of liver has occurred.*

Positive test is about 100 per cent accurate for acute hepatitis if performed early; a negative test after two weeks may occur in acute hepatitis.

A negative test if performed early means:

- Mechanical block
- Obstructive catarrhal jaundice due to involvement of the bile ducts
- Or, a normal liver (e.g., hemolytic jaundice)

The results of urobilinogen tests are most valuable when one is performed daily for several days, i.e., a single test does not yield as much information as repeated tests.

#### *Hippuric acid test\**

Give 5.9 gm. of sodium benzoate in 30 c.c. of water, one hour after a breakfast of coffee and toast, and is followed by

one-half glass of water. Patient voids. Then urinates every hour for four hours.

Specimens are acidified to Congo Red with HCl.

The ppt. of hippuric acid is collected on a filter paper, dried and weighed.

Total hippuric acid eliminated by a liver with some reserve is from 3 to 3.5 gm.

This test determines one of the detoxicatory mechanisms of the liver. It should help to determine the choice of anesthesia. The synthesis of hippuric acid is related to the function of bile acid synthesis. Relief of stasis by surgery does not mean an immediate return of the liver to normal. With the exception of the hippuric acid test, in the absence of drainage of bile via a fistula, some claim that we have no other test better indicating the recovery of the liver. I have reason to believe, however, that *bilirubin clearance* (rate of disappearance of injected bilirubin from the blood), or possible *bromsulphthalein* clearance, will in time prove to be a more sensitive test of liver function, not of diagnostic but of prognostic value, than the hippuric acid test.

It is well to remember that serum phosphatase is markedly elevated in obstructive jaundice. It is elevated in various conditions producing hepatic cell damage. It has not been shown to be of value in the differential diagnosis of obstructive and intrahepatic jaundice.

Table I is a summary of the results obtained by Dr. Rosenberg, with the galactose and urobilinogen tests.

The results clearly demonstrate the usefulness and limitations of the two tests.

The diagnosis of a hemolytic type of jaundice is not generally considered to be difficult. The more important points follow:

Hemolytic jaundice, uncomplicated and hereditary

- Hereditary factor.

\*Quick. Am. J. Med. Sci., 185:630, 1933.



TABLE II

Test	Acute Hepatitis	Cholelithiasis, Catarrhal Jaundice	Mechanical Obstruction
Bile in duodenum	May be none Occasionally in early stage	May be none at times	None, if complete
Urobilinogen in urine	Present or absent depending on whether bile pigment enters gut	Present or absent depending on whether bile pigment enters gut	None, if complete
Galactose tolerance test	Positive if performed within two weeks. May be negative later	Negative	Negative, unless acute liver damage is present
Cholesterol plasma serum	Esters decreased; total high early; normal or hypo-normal later	High in early cases	High, particularly in early obstruction
Duodenal drainage	Bile lightly pigmented, and no crystals	Pus cells. If bile pigment is obtained, there are no bilirubinate or cholesterol crystals	Blood in carcinoma. Cholesterol and bilirubin crystals if stone is in duct.
Stools	Bile pigmented usually	Bile pigmented usually	Blood in carcinoma alcoholic if complete
Hippuric acid test	Subnormal elimination	Subnormal elimination	Subnormal elimination

- b. Splenomegaly, usually.
- c. Increased reticulocytes, microcytes, and increased fragility of red blood cells.
- d. Indirect van den Bergh.
- e. Normal cholesterol; phosphatase normal.
- f. Normal galactose and hippuric acid tests.
- g. Urobilinogen in the urine; but little or no pigment; hence the name "acholuric jaundice." Urobilinogen in urine because there is plenty of pigment in alimentary tract, and liver is too heavily burdened with pigment to convert urobilinogen into bilirubin.
- h. Bile in duodenal drainage.
- i. Heavily pigmented stools.

These patients may have biliary colic from pigmented stones.

The differentiation between acute hepatitis, cholelithiasis and mechanical obstruction is not easy. (It is not in the province of this discussion to give the differential points of importance in the history and physical findings.) The laboratory results are outlined in Table II.

From a study of the table it is to be noted that laboratory diagnosis alone will not differentiate between medical and surgical painless jaundice. The history and physical findings and the experience of the clinician

rank first in importance. But, the tests shown in the table should frequently be of considerable help. I consider the results of the galactose, urobilinogen and duodenal drainage tests to be the most helpful.

I should never operate on the biliary tract of a jaundiced or non-jaundiced patient without performing before hand *an hippuric acid test or bromsulphthalein liver function test*, and *determining the bleeding time and coagulation time of the blood*, except when emergency is definitely indicated. One, of course, must also consider the condition of the kidneys and heart.

#### Physiologic Disturbances Incident to Obstructive Jaundice

*Cause of death* is unknown. It is probably due to hepatic insufficiency. A terminal renal insufficiency occurs.

The presence of bile salts, which are the only known toxic constituents of bile, in the blood stream are probably not the cause of death because after several weeks the bile acid content of the blood decreases. In obstructive jaundice hepatic damage is known to occur; icteric necrosis, biliary infarcts, or biliary cirrhosis are found at autopsy. Further, hepatic regeneration does not occur to any appreciable extent.

The accumulation of pigment in cells *per se* is not serious because the patient with familial jaundice or the jaundice of hypertrophic cirrhosis may survive for years, dy-

TABLE III

	Cases	No Bleeding Tendency	Bleeding Tendency	Results On those Patients Who Manifested a Bleeding Tendency
Chronic Cholecystitis and lithiasis	254	219 D O? P.O.D. O	35 13.7% 320"	24 given viosterol, bleeding time reduced to 130". No deaths. 2 P.O.D.  11 Controls, bleeding time cont. at 346". No deaths. 10 P.O.D.
Common duct stone	64	25 D O P.O.D. O	37 57% 330"	24 given viosterol, bleeding time reduced to 120", in all except 1. This patient died. 1 P.O.D. in the rest.  13 controls, bleeding time rose in 11, 385". Deaths 5. P.O.D. 8.
Surgical malignancies	24	14 13 op't. D 1? P.O.D. O	10 430"	8 given viosterol, in 6 bleeding time reduced to 190". 1 died, cardiac decompensation at 2.5 wk. In 2 viosterol had no effect. 1 died; stormy P.O.D.  2 controls, bleeding unchanged. Deaths 2, Chol. emia.

ing from a ruptured varix or evident hepatic insufficiency.

Dogs with obstructive jaundice generally die in three months, but occasionally survive six to twelve months. In man obstructive (complete) jaundice generally proves fatal in from four to six months, although some cases have survived much longer, although the possibility of a fistulous tract to the intestine has not always been ruled out in such cases.

*Osteoporosis* occurs in chronic icterus and is probably due to failure of the absorption of Vitamin D and the decreased absorption of calcium. Since in the absence of bile salts from the intestine fatty acids are not normally absorbed, they form Ca soaps and are passed in the stools.

*Hemorrhagic tendency.*—In some patients the fibrinogen value is decreased; in others the clotting time is prolonged, or the prothrombin is decreased; others apparently manifest prolonged bleeding when these factors are apparently normal. This suggests a disturbance of the retractility of the blood vessels. The clotting time may be normal, but the clot may lack firmness. No appreciable change in blood Ca is present.

*Bradycardia* occurs early in jaundice, and is more evident in young patients. It is probably due to bile salts, which increase the cardiac vagal tone. Liver injury may cause bradycardia.

*Pruritus.*—Cause unknown. Said to be

relieved by 1 mg. ergotamine orally or by the administration of bile salts orally.

#### Bleeding Tendency in Jaundice

Two very distressing complications are frequently encountered after surgery on the bile tract. The first is hemorrhage. The bleeding tendency in jaundice is undoubtedly related to the degree of liver damage. The mechanism of this relation is obscure, but the clinical facts are obvious. According to the reports from several clinics, 50 per cent of all postoperative deaths in patients with jaundice, or liver insufficiency, are associated with or the result of hemorrhage. Many clinical and laboratory methods have been recommended to determine the existence of the bleeding tendency, but none have been accepted as a reliable guide. As Colbeck has said, there is no definite method as yet for the evaluation of the bleeding tendency in jaundice.

The "venostasis bleeding time," suggested by the author, has been used successfully by McNealy and others. The method consists in placing a sphygmomanometer cuff about the upper arm with a pressure of 40 mm. Hg. to prevent venous return. This was done to increase the pressure in the peripheral vessels with the idea that the effect of any defect in retractility of the vessels, in clotting time, or in the firmness of the clot might be exaggerated. The skin of the forearm near the elbow over the pronator muscles is the site of the puncture. The punc-



ture is made with a mechanical stylet set at a uniform depth. We used a depth of 3.0 mm. This gave a bleeding time in over 100 normal subjects ranging from thirty seconds to three minutes. The upper limit of normal was set at 240 seconds. The blood was blotted with filter paper every ten or fifteen seconds.

A portion of the results obtained by McNealy, Shapiro and Melnick are shown in Table III.

Bile salts were administered to jaundiced patients with the viosterol, Vitamin D, to insure its absorption.

A study of Table III shows that bleeding time is of prognostic value and that viosterol improves prognosis, and that if viosterol does not work prognosis is bad.

A second complication, which does not occur as frequently as hemorrhage after surgery on the bile tract, is the so-called "liver death." This condition is characterized by a rise in temperature and pulse rate, anuria and uremic manifestation (azotemia). Autopsy reveals extensive regeneration of the liver and renal parenchyma. "Liver death" may also occur after traumatic rupture of the liver.

Three clinical groups (Heyd<sup>3</sup>) have been recognized. These groups are characterized as follows: (At least ninety-five cases have been reported).

*Group 1. "Rapid high temperature death."*

- a. Long clinical history of biliary tract disease, but apparently a good surgical risk. Blood and urine are normal.
- b. Patient passes into a semicomatose state after cholecystectomy.
- c. Temperature rises rapidly and death occurs in from twenty-four to forty-eight hours.

*Group 2. a. Patient is jaundiced and does not appear to be as good a risk as the patient in group 1, but is "properly prepared for operation," and is not apparently a bad risk.*

- b. At first a routine recovery occurs after some operation on bile tract.
- c. But, after two or three days, patient becomes somnolent, irritable, distended, and restless. Then,
- d. Oliguria, coma and death follow.

*Group 3. a. Patient has symptoms of calculous cholangitis, or cholecystitis possibly with involvement of the pancreas.*

- b. At first a routine recovery occurs after operation.
- c. But, after five or six days, oliguria develops, which may develop into anuria and death with symptoms of uremia.

Before considering this question further, cholemia should be described. Cholemia is a term used to designate a group of symptoms which commonly terminate a chronic icterus. These symptoms are: irritability, restlessness, melancholia, rapid pulse, slight fever, dry tongue, coma, delirium or convulsions and death. Cholemia is preliminary to or associated with the hepatorenal syndrome.

The "rapid high temperature death" characteristic of group 1 is not characteristic of operations on the biliary tract alone. It can occur after operations elsewhere. So, its relation to the liver is uncertain.

In groups 2 and 3, where jaundice may be absent, the death appears to be due principally to renal insufficiency, since at the time of onset of the symptoms blood sugar may be normal, and urea, which is formed by the liver, is still being formed and steadily increases in the blood, and bile may be present in the stools. At autopsy the epithelium of the convoluted tubules is found to be degenerated and areas of necrosis and fatty degeneration are found in the liver. This condition is referred to as a "hepatorenal syndrome." Such a syndrome may occur also in burns, intestinal obstruction, and hyperthyroidism.

*Experimental production.*

1. In rabbits, ligature of the left portal vein caused atrophy of two-thirds of the liver, oliguria, albumin, casts and red cells in the urine.
2. In rabbits, obstruction of the common duct followed by releasing the obstruction produced the clinical and pathologic picture of the hepatorenal syndrome.
3. Injection of a saline or watery extract of the liver of a patient dying from a "rapid high temperature death" into rabbits caused rapid high temperature death.

*Theories*

1. Necrosis of the liver results in the release of a powerful toxic substance which injures the kidney.
2. Necrosis of the liver releases foreign protein into the blood in such quantities that the capacity of the kidney to excrete it is overtaxed.

*The important point to remember is that in every biliary tract disease, the factor of safety in the liver is impaired to a greater or lesser extent. Hence, much attention should be given to the proper preparation of the patient for operation and to the selection of the anesthetic.*

The medical aspect of the treatment of jaundice is that for the treatment of hepatic insufficiency, that is to

Improve the detoxicatory and other functions of the liver.

1. Glucose.

A liver filled with glycogen suffers less from chloroform and phosphorus poisoning.

The meat intoxication of Eck fistula dogs is improved by glucose intravenously.

Animals and patients with chronic hepatic insufficiency do better on a high carbohydrate diet.

An injection of glucose may improve the coagulability of the blood in the jaundiced patient.

Ascites is more likely to occur in cirrhosis of the liver, if a high protein diet is fed than if a high carbohydrate diet is fed.

Glucose combats starvation ketosis.

2. Calcium.

Calcium protects the liver from carbon-tetrachloride poisoning.

Calcium intravenously improves the coagulability of the blood at least temporarily (six to twenty-four hours) in jaundice.

Vitamin D with bile salts in jaundice improves or returns to normal the bleeding time, if any hepatic reserve is present. Vitamin D, like carotene, the precursor of Vitamin A, is absorbed only when bile salts are present in the intestine. Vitamin C has been injected intravenously in hemor-

rhaging patients with apparently good results. Vitamin K (antihemorrhagic vitamin in chicks) said to be of value in hemorrhage of jaundice; also certain flavins, Vitamin G.

3. Blood transfusion.

The hemoglobin in grave jaundice and hepatic insufficiency shows undersaturation with O<sub>2</sub>. In grave cases a transfusion should improve protein composition of the blood and oxygenation of the tissues, and benefit anemia when present.

4. Diet.

Dogs with hepatic insufficiency do best on a milk, cereal or bread, and corn syrup diet. They must have some protein. I have recommended an addition of glycine in the form of large quantities of gelatin. I believe extra vitamins should be supplied in concentrated form. Also, theoretically in chronic cases, glucuronic acid in some form, e.g., chondroitin, should improve the detoxicatory function of the liver.

5. Bile Salts.

In the presence of hepatitis or a liver that does not spontaneously secrete some bile, bile salts have no or only a slight effect. In hepatic insufficiency or hepatitis, bile salts are either not secreted in the bile or only to a slight extent.

It has not been proven that the administration of bile salts, after the surgical relief of jaundice or after the partial recovery of the liver from hepatitis, will increase the rate of disappearance of the jaundice, or improve liver function.

After partial recovery of the liver, bile salts do increase the volume output of bile.

They should be given in complete obstruction of the common duct to aid the absorption of Vitamins A and D.

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## BRONCHO-SINUSITIS\*

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The purpose of this discussion is to promote a more general recognition of the conditions causing bronchiectasis and the adoption of appropriate methods for their control.

The title, broncho-sinusitis, was suggested by Wasson<sup>18</sup> in 1929 for infections involving the entire respiratory tract and particularly those of a chronic character.

Thompson<sup>14</sup> suggested, some seventeen years prior to this, that persistent bronchorrhea might result from chronic sinus suppuration. The subsequent years have produced numerous researches and extensive clinical papers to prove this assumption.

Sargent,<sup>12</sup> Rist,<sup>10</sup> Webb and Gilbert,<sup>19</sup> Peroni<sup>8</sup> and others have emphasized the importance of thorough sinus examination in cases of pulmonary disease.

Mullin and Ryder<sup>6</sup> have completed their classic studies on the lymphatic drainage of the nasal sinuses and the course of material aspirated into the tracheobronchial tree from the naso-sinus secretions. Opie<sup>7</sup> has demonstrated that influenzal pneumonia is almost invariably accompanied by sinus infection.

Graham<sup>3</sup> has called attention to the frequent acute inflammation of the mucosa of bronchial fistulae occurring about twenty-four hours after an acute infection of the sinuses and subsiding with the improvement of the disease in these cavities.

Numerous observers have variously reported the frequency of the association of chronic sinusitis and non-tuberculous bronchiectasis. Quinn and Meyer<sup>9</sup> report 58 per cent. Dunham and Skavlem<sup>2</sup> 73 per cent, Hodge<sup>4</sup> 75 per cent, and Clerf,<sup>1</sup> 82.4 per cent.

Many authors insist that the naso-sinus disease is the primary cause of the bronchiectasis. The clinical evidence and researches would seem to prove this. Most writers are of the opinion that the whole respiratory mucosa is affected and that the bronchitis and pneumonitis fails to resolve because of the continued infection in the sinuses.

A proper understanding of the relationship of the part played by the sinuses in acute and chronic bronchitis, bronchiectasis and pulmonary abscess presumes a knowledge of the normal and pathological physiology of the sinus linings, and general knowledge of their vascular and lymphatic drainage, together with the mechanics

which result in aspiration or droplet infection.

It is my purpose to discuss briefly the mechanics of normal sinus and nasal drainage; to discuss the lymphatic and vascular drainage in these areas and to demonstrate that this drainage may and does frequently result in involvement of the lymph glands in and about the bronchi, as well as the bronchial linings, in a manner which is difficult to differentiate from childhood tuberculosis. I wish to demonstrate further that a reversal of the course of the bronchial infection may occur in the aspiration types in a manner to directly parallel the inception and spread of infection in childhood tuberculosis, to produce a clinical picture which can be differentiated on the basis of one or two findings only and to correlate this knowledge with the general recognition that bronchiectasis results from inflammation weakening of the bronchial walls. Finally, I wish to discuss adequate and proper methods of sinus examination; to demonstrate the pathological changes found in sinus linings and to express an opinion as to efficient management.

We will trace the course of an infective agent from the time of its entrance into the nose or sinuses until a lesion of the bronchi, pulmonary tissue or the local lymph glands is produced.

The nose and sinuses are lined with ciliated, columnar epithelium and provided liberally with mucus-producing goblet cells. These cilia move in successive rows to produce a picture similar to a field of grain which is blown by the wind. The secretion of the goblet cells provides a sticky, viscous, rubber-like sheet which coats the tips of the cilia and is propelled toward the naso-

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pharynx in the one case and toward the normal ostia of the sinuses in the other. Definite directions of movement carry the trapped foreign material directly backward from the nostrils and downward and backward from the side walls of the nose.

We must keep in mind that the sinuses are not in nor a part of the nose, but, rather, that they are accessory to it. They ventilate and drain into it. The direction of the ciliary wave motion of its linings is always toward the ostia and drainage is unaffected by artificial openings in any other area. *Infection* or chemical substances *may retard or paralyze the cilia and produce a situation favorable for absorption.* Under normal conditions a dye particle introduced into the nostril travels from three to four inches to appear in the nasopharynx in ten minutes.

It is at this point—e.g., the presence of secretion in the nasopharynx—that differences of opinion arise. One group contends that all bronchial infections secondary to the nose and sinuses result from aspiration, while another maintains that the mechanics of movement from this point onward plus the protective mechanism of the larynx and trachea, preclude such extension. They maintain that all such infections travel via the lymph and blood streams.

There should be no such controversy because the facts were clearly demonstrated by Mullin and Ryder<sup>6</sup> seventeen years ago, and have since been supported by the experiments of other workers.

A solution of india ink, allowed to flow into the nose, was rapidly inhaled. The effects in the lung were characterized by quick development and a massive character. The absence of any signs of absorption along the cervical or mesenteric lymphatic routes gave convincing evidence of production by pure inhalation.

This experiment was repeated with an injection of an emulsion of tubercle bacilli and the animal examined seven weeks later.

The lungs showed advanced tuberculosis of the right upper and middle lobes, with consolidation and moderately advanced tuberculosis of the bronchial nodes. The cervical nodes, spleen and mesenteric nodes were all negative.

The extension of infection from the nose to sinuses is a well-established and accepted fact. It is certain that the ethmoid cells are

involved in every protracted cold and that, in many instances, this infection remains latent after the immediate local disturbance subsides. We have just noted that drainage from these areas may reach the bronchi, etc., by the inhalation route. Mullin and Ryder also demonstrated experimentally that infection from the sinus cavity linings travels through the lymph channels and blood stream to produce the same type of lesion. They injected carbon particles and tubercle bacilli in the lining of a closed maxillary sinus and produced the same bronchial and pulmonary lesions obtained in the aspiration experiments. This work has since been supplemented by the splendid researches of Logan Turner, Pickworth and others on the pathways of infection from the sinus to the brain, as well as by many clinical observations. It has been confirmed recently beyond dispute. The trachea of an animal was resected and sutured into the neck before repeating the experiment. The results were identical.

The venous return from the posterior two-thirds of the nose and all of the sinuses other than the sphenoid collect in tributaries of the pharyngeal plexus. This plexus forms a mesh about the vault, posterior and lateral walls of the pharynx which freely connects with the tributaries of the superficial and deep jugular veins and with the intracranial base sinuses by a mesh of veins accompanying all arteries and nerves through the foramina of the cranial base. Lymphatics follow these routes. This accounts for enlarged, inflamed lateral bands and the granular pharynx in sinus disease.

The lymphatic glands related to the lower respiratory tract are classified and described by Delamare as follows:

#### Bronchio-mediastinal glands

- (a) Peri-tracheo-bronchial glands
- (b) Inter-tracheo-bronchial glands
- (c) Inter-bronchial glands.

The peri-tracheo-bronchial glands, which are designated as right or left, are about the size of a large pea. The glands on the right are larger and more numerous than those on the left. On both sides they are in intimate relation with the tracheo-bronchi, the inferior vena cava, the surface of the lung, the pulmonary artery, the vena azygos major, the recurrent laryngeal and



the pneumo-gastric glands. They are uneven in size and are more numerous under the right than under the left bronchus. Their anatomic relations are with the bifurcation of the trachea above, with the pericardium in front and behind with the pulmonary plexus and the anterior surface of the esophagus.

The inter-bronchial glands occupy the angles of the divisions of the larger bronchi and may be found even in the divisions of the fourth order. These glands are completely buried in the pulmonary parenchyma. They are in intimate relation with the branches of the pulmonary vessels, particularly with the pulmonary artery, which they may compress when enlarged.

It is easy to understand, from this description, how infection with resultant enlargement of these glands and involvement of the musculature and mucosa produces cough and pressure on important structures, as well as retention of secretions within the finer bronchi. We must go a step further to account for the bronchiectasis.

Robinson<sup>11</sup> has demonstrated from surgically removed bronchiectatic lobes that chronic inflammation of the bronchial wall, with frequent complete destruction of the muscle and elastic tissue is the most common pathologic finding.

Warner and Graham<sup>17</sup> have demonstrated on similar material that bronchiectasis may occur with neither fibrosis nor pleural adhesions.

We need only to determine the physiologic forces causing the dilatation. "These forces are, first, the direct pull of the expanding thorax on the bronchi, transmitted through the parenchyma; second, the difference in pressure between that in the lumen of the bronchus and that outside its wall occurring on inspiration. On expiration the bronchus becomes narrowed, owing to its elastic tissue, which becomes effective with the cessation of the forces causing dilatation."

"The forces causing physiologic dilatation acting on a bronchus which has lost much of its muscle and elastic tissue, such as occurs in bronchiectasis, will cause a dilatation greater than normal on inspiration, since there is not the elasticity to overcome. The bronchus will not return to its normal expiratory size with the cessation of the

dilating forces, since its power of contraction is diminished on account of the loss of elastic and muscle tissue in its wall. Therefore, the forces causing physiologic dilatation, if applied to a weakened bronchus, as found in bronchiectasis, will cause permanent or pathologic dilatation." (Warner<sup>16</sup>)

Atelectasis and fibrosis of the lung parenchyma increase the forces causing the permanent dilatation. The accompanying cough is also a potent factor in this accomplishment.

What is the sinus pathology producing or maintaining the bronchial changes?

a. It may be acute or chronic, hyperplastic or purulent. It may or may not produce exudate in quantity sufficient for appreciable drainage and this drainage may vary from a thin, dirty, gray watery secretion to a thick, creamy pus. The presence or absence of pus is not a criterion.

The local soft tissue change may vary from simple congestion to total necrosis with abscess formation. Tilley<sup>15</sup> points out in a recent article that there is frequently residual infection in the bony capsule of a sinus which is a potent focus of vascular infection.

The symptoms of bronchiectasis are typical. Warner<sup>16</sup> states that the onset of most cases may be determined by the history alone. The common local symptoms are "a cough and sputum influenced by posture and the sputum moderate in amount, often accompanied by blood spitting and usually not foul smelling but practically always chunky." In his experience only 20 per cent of the patients had the large quantity of foul sputum of the classic picture. Blood spitting occurred in 45 per cent and the "dry" type occurred in only 2 per cent.

Much of the damage is already done in these cases, but, regardless, the sinuses should be carefully appraised and adequately treated in the effort to check the progress of the bronchial lesion. The treatment of the advanced bronchiectasis is surgical but this should not be undertaken until the sinus condition has been properly managed.

It is our desire to awaken an interest in the earlier lesions such as frequent recurrence of colds, bronchitis and coughs in infancy and childhood. We may add the cases of unverified childhood tuberculosis.

One may aptly quote an old axiom that "an ounce of prevention is worth a pound of cure." Chronic bronchitis and bronchiectasis has its origin frequently in the minor maladies of infancy and childhood. It is our desire to prevent the child of today from becoming the bronchiectatic of tomorrow.

The infant is occasionally born with pus in the nose and antrum and very frequently suffers a birth injury which lays the foundation for much future difficulty. I am referring to the dislocation of the cartilaginous septum which was described by Metzenbaum.<sup>5</sup> Pressure on the nose during delivery dislocates the cartilage from its groove in the vomer to produce a characteristic deformity which is easily recognized and readily corrected with the fingers. This is probably one of the commonest causes of the septal deformities which are noted so frequently in later life.

The child with frequent head colds has an ethmoid involvement or such an involvement linked with infection of the antrum. The background for this may be dietary, metabolic or mechanical as the result of deformities, but the fact remains that such infection is residual in these cells. The frequent head colds are an exacerbation of the latent process. In due course bronchitis accompanies the cold. The infection has traveled via the lymphatics and the bloodstream to involve the bronchial lymph glands or inspiration infection has occurred. The whole process may be healed in most cases by proper attention to the existing sinuses, that is, the antrum and the ethmoid, together with proper care of the tonsils, adenoids and any local nasal disturbance.

Much of the treatment carried out is of little value and in some cases of positive damage. The use of solutions and drops to shrink the membranes and diminish the mucus secretion is an affront to nature's effort of correction. The congestion, the increased flow of mucus and the rapid exfoliation of surface cells are all efforts to localize and carry away the invading organism. The treatment should be systemic rather than local. "Packs" with silver solution, et cetera, during the subacute and chronic stage have a value in regulating the local circulation and a possible slight secondary effect on the sinus linings, but none of the drug can nor

does enter the involved sinus cavity. I wish to emphasize again that the sinuses are in no way a part of the nose, but are accessory to it. The increased mucus which follows the use of these packs results from the local irritation of the drug and does not come from the sinus cavities. A proper treatment should consist of dietary arrangement, correction of metabolic faults, displacement of ephedrin into the ethmoid cells and other cavities by the Proetz method, where the age of the patient permits, stimulation of the histiocytic defense by one or more small doses of x-ray and, possibly, one or more irrigations of the infected cavity. A single such irrigation frequently suffices to clear up the process. One or more such x-ray treatments, with proper internal medication frequently checks the bronchitis and eliminates the cough.

In late adolescence and adult life we find the evidences of chronicity with many or all of the pathological changes already described. The lining membrane, long the site of chronic infection, is no longer a mucus membrane but a pathological menace which demands treatment as such. It must be as completely eradicated as such pathology elsewhere in the body.

I wish to call attention to a most important finding in the history and local examination which receives scant, if any, attention. I am referring to the statement of the patient that he has a mild catarrh and the observation upon the part of the examiner of a scant, thin, gleet-like discharge post-nasally and in the naso-pharynx. A sinus lining producing drainage of this type is most prone to cause systemic, psychic and mental pathology. Both the examiner and the patient are much concerned by the presence of thick creamy pus but only casually interested in the scant watery discharge. The pus is evidence of a good local phagocytic defense, whereas the thin discharge results from a feeble local resistance. Such a discharge exuding from a wound in the hand or the arm would invariably be accompanied by a lymphangitis and frequently result in grave systemic involvement. Such evidence in the nose or naso-pharynx demands the most careful investigation and care.

All cases of chronic sinus disease are not surgical. The management depends on the



chronicity of the disease and the type of infection. One group demands local and dietary management while another has a hypometabolic background. Another group of border-line cases should be given the benefit of every type of useful local and general treatment over a sufficient period of time before resorting to surgery. A third group of patients is distinctly surgical. All ethmoid cases in which there are no other involved sinuses and in which the cells still contain some air are given long periods of displacement treatment before resorting to surgery. A large proportion of this group of cases recover without surgical intervention. In other instances where the cells do not contain air, in other words where they have been filled with hyperplastic membrane, surgery is demanded. It is obvious that medication cannot be introduced into a cavity that has no air content. The use of drops, sprays, packs, et cetera, locally in such cases is pure fraud and should be abandoned. In those cases where surgery is demanded, the cavity should be approached under direct vision in order that the diseased lining may be completely and meticulously removed. Every vestige of such a lining must be removed in order to prevent some recurrence of the disease. (Smith<sup>13</sup>)

The rhinologist is to blame for the attitude of the internist and the afflicted public towards surgical intervention in this locality. It results from his failure to accomplish a cure by the half measures which

have been practised intra-nasally and in the local care of the cavities.

A clearer appreciation of this problem by both the internist and the rhinologist, with a proper surgical management of these patients, will regain the confidence of the public and eliminate ultimately much of the present distressing problem.

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### Management of Facial Injuries Caused by Motor Accidents

To obtain successful and satisfactory end-results in the surgical treatment of facial injuries, a systematic examination of the patient is of primary importance. Claire L. Straith, Detroit (*Journal A. M. A.*, Jan. 9, 1937), suggests that it include careful inspection and cleansing of all lacerations, with removal of gross foreign bodies, careful palpation of all facial bones, palpation of the nose and intranasal inspection and inspection and palpation of the oral cavity. Facial disfigurements are a source of great mental anguish and not infrequently engender psychologic handicaps that ruin social and business careers. In spite of every precaution, infections as well as other complications may supervene and make immediate surgical treatment impossible. Scars, crushed facial bones, loss of eyebrows, ears and nose—all such disfigurements require subsequent correction if the victim is to take his place again in society. Plastic procedures should not be undertaken, how-

ever, until the lapse of two months after every vestige of infection has disappeared. To intervene prematurely in these cases is to court disaster. Old scars should be excised and resutured with subcuticular stitches. Depressions of the nose, forehead or malar prominences should be built up with rib cartilage transplants. Before applying the cartilage transplant, one should make a lead model made from a plaster impression of the face. At the operation, the cartilage should be trimmed to fit the depression on the sterilized lead model. This ensures greater accuracy in restoring the normal contour. Severed noses may be replaced by plastic procedures. It is important that the skin to be transplanted should match the integument of the face in both color and texture. In women, the forehead flap method is most satisfactory. The resultant forehead scar can easily be concealed by the hair dress. In men the skin beneath the ear and overlying the sternocleidomastoid muscle is preferable. This is brought to the face by way of a tube pedicle.

## YEAST DERMATOSES: CONTACT DERMATITIS\*

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The affections included under the above titles are not related to each other, but their discussion seems justified on account of their importance in cutaneous medicine. Investigation has shown that a number of cutaneous and mucous membrane affections formerly described as entities have been found to be due to yeast or yeastlike microorganisms. Among the cutaneous affections are erosio-interdigitalis, perlèche, waterbed dermatitis, paronychia, onychia, and, possibly, seborrheic dermatitis. In addition, a mycotic dermatitis frequently occurs beneath the breasts in fleshy women, in the axillary spaces, in the ano-genital region, and occasionally

the affection becomes generalized. Two or more or all of these affections may co-exist in a given patient. Through experimental work all have been produced by inoculation of cultures taken from patients exhibiting the various types of dermatitis.

### Yeast Dermatoses

*Erosio-Interdigitalis*.—This type occurs on the web of the fingers, usually on the third and fourth interspace. It may occupy all of the interspaces and it sometimes occurs between the toes. It is characterized by a shiny red area surrounded by a collar-ette of scales, or it may be represented by an accumulated mass of sodden, moist, whitened epidermis. Vesicles are usually absent, though points on the reddened area may indicate former vesiculation. This form of moniliasis is exceedingly difficult to eradicate.

In addition to the erosio type of lesion, a vesicular and papulo-vesicular eruption occurs in the interdigital surfaces with occasional maceration and fissuring.

*Perlèche*.—In this condition, there is an inflammatory reaction occurring at the angles of the mouth, usually in children. It is characterized by a thickening and whitening of the epithelium, together with fissures. The affection sometimes spreads toward the center of the lip and over the glabrous skin in the immediate vicinity. The thickened epithelium, often likened to mother-of-pearl, is sometimes easily detached. Occasionally, a moderate degree of crusting occurs. The

fissures are superficial and rarely bleed and ulceration does not occur. A scaling dermatitis of seborrheic type sometimes occurs in the immediate vicinity.

*Waterbed Mycosis*.—This form is characterized by the development of herpetic-like vesicles with red areolæ, together with pustules. These develop in a continuous water bath or on areas of the skin where moist dressings are applied over a considerable period of time. A frequent site is the abdomen, following laparotomy where moist hot dressings have been employed. At times the inflammatory reaction becomes marked, in which case redness, edema, weeping and crusting occur.

*Paronychia*.—Mycotic paronychia presents a characteristic picture and occurs in two forms, acute and chronic. The acute form is quite generally distributed, but occurs frequently in workers in fruit canneries and other industrial laborers. The chronic form presents a characteristic picture described by MacLeod as a "pad or bolster-like swelling of the nail wall." This enlargement is most marked at the base of the nail and gradually tapers down on the sides toward the distal end of the nail plate. The degree of inflammation varies in different cases and there is usually an associated dystrophy of the nail plate, due to interference with the formation of the nail at the lunula. In acute cases, such as described by Kingery and Thienes, seen in workers in fruit canneries, there is much swelling and pain and often shedding of the nail. These cases, together with those de-

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scribed by Sutherland Campbell produced by orange juice, are industrial dermatoses.

Monilial onychia resembles the ringworm type. In the chronic form transverse ridges occur in the nail plate and it becomes opaque, thickened, discolored and brittle. Subungual keratoses are present beneath the lateral and distal portions of the plate, causing it to be raised from the bed.

*Dermatitis Seborrhæica.*—The clinical description of this form of dermatitis will not be outlined as it is familiar to all. The point of interest in this connection is the fact that a yeast-like organism, spore of *Malassez* or *pityrosporon* of *Malassez* was cultivated by MacLeod and Dowling from all types of this affection and the disorder reproduced by experimental inoculation. In their work they found it necessary to inject the cultures intradermally or to rub them into lightly scarified areas, to reproduce the affection.

*Glabrous Skin Types.*—On the glabrous skin a mycotic dermatitis is characterized by variously sized, well-defined, circular, red, scaling patches. By fusion gyrate configurations are produced. Moist crusting patches, suggesting eczema, occasionally develop, while in widespread cases there occurs simply a dry dull red scaling dermatitis. Patches begin with vesicles or vesico-pustules, which rupture, leaving denuded red areas surrounded by rings of detached epidermis. These spread peripherally and by coalescence with others form the patches. By the development of new vesicles in the vicinity and their undergoing the above evolution, large areas become invaded. In the crotch and beneath the breasts and in other intertriginous regions, the bottom of the cleft is usually fissured, while the skin in the involved area is shiny, light to dark red, presents some moisture and has scale covered margins which are polycyclic in outline. When the ano-genital region is involved, varying degrees of itching occur, for the relief of which scratching is practiced, which results in thickening, excoriations and fissuring of the skin. In the anal region the erosio type seen between the fingers is sometimes present.

Patches of dermatitis characterized by redness and vesiculation, scaling and crusting, may also be found on the dorsum of

the hands and on the forearms. Involvement of these areas frequently occurs in association with paronychia seen in workers in fruit canneries.

*Monilial Infection of Mucous Membranes.*—In addition to thrush, which has long been known to be of mycotic origin, other forms of stomatitis and glossitis occur. As there is no symptom-complex characteristic of monilial infection, and as these organisms are sometimes found as saprophytes in such diseases as syphilis, some difficulty is encountered in recognizing these affections.

On the lip and buccal mucosa and on the mucous membrane of the pharynx and larynx, grayish white membranous pellicles of varying dimensions are seen. These pellicles are translucent and usually easily detachable. They also occur on the tongue and gums. Occasionally there is apparently more thickening when the pellicles become more adherent, and when detached leave superficial erosions, thus presenting a clinical picture of leukoplakia.

On the buccal mucosa Engman and Weiss early described a lesion which occurred as a glistening white mat of filiform projections situated on a white macerated base.

On the tongue Zeisler described scroll-like patterns resembling geographic tongue. Robinson and Moss described an acute form in which the papillæ were absent, and the surface of the tongue presented a smooth or slippery appearance like wet, red rubber. Miller and Morrow described a deep form in which a gumma-like lesion developed in the soft palate in the tonsillar region. This lesion developed acutely and caused perforation of the soft palate.

*Etiology.*—Cutaneous and mucous membrane mycotic infections may occur at any age from infancy on and in both sexes. Paronychia is at times an occupational affection induced in the cases described by Kingery and Thienes by contact with fruit juices in cannery workers, and by orange juice in cases described by Sutherland Campbell. It frequently occurs in women who handle sugar, such as those employed in confectionery factories, and in pastry cooks and so on. Diabetes is occasionally a predisposing factor in the waterbed type. In-

fection of the skin in infants frequently comes from oral and intestinal thrush and in adults not infrequently from the stools. The organism most frequently found is *monilia albicans* (formerly *oidium ablicans*). *Cryptococci*, *pityrosporon* of *Malassez* and other yeast-like organisms are also concerned in the production of these mycoses.

*Diagnosis.*—The major portion of cases of mycotic infection of the skin due to *monilia* and related organisms usually present sufficiently characteristic symptoms for their recognition. A microscopic examination in all cases is essential. Scrapings from the lesions are mounted on a slide in a 10 per cent to 25 per cent solution of sodium hydroxid, over which a cover slip is applied, and gently heated. The organism shows plainly and presents the following characteristics with a medium high power objective. Mycelium and spore-like bodies are seen. The mycelia are more delicate and less refractile than those of ringworm. Septa are rarely demonstrable. Oval spore-like bodies with buds attached to the ends are also present.

In young cultures the organism appears chiefly as round or oval cells, which multiply by budding. In old cultures hyphae develop

*Treatment.*—Oral thrush in infants responds well to swabbings with a 1 per cent solution of gentian violet, together with mild alkaline mouth washes. For superficial lesions of the mucous membranes of the mouth and vagina, a 3 per cent solution of gentian violet is efficient, using it as a swab twice daily. Alkaline mouth washes for the oral cavity and a douche containing a 1:2,000 solution of potassium permanganate for the vagina facilitate recovery. For the deeper lesions on the oral mucosa, surgical excision, roentgen rays and the internal use of potassium iodid may be necessary.

Paronychia responds readily to the local application of a 5 per cent suspension of chrysarobin in chloroform. This is very efficient and was originally recommended by Morrow and Lee for treatment of chronic paronychia before moniliasis had been recognized. In the erosio type, which is resistant, the parts are to be kept dry. The local application of chrysarobin in the

strength of 5 per cent or 10 per cent, or tincture of iodine, is valuable. In the water-bed type suspension of wet dressings, together with the application of a soothing lotion, such as the aqua calcis and zinc oxide lotion, together with a 10 per cent naftalan, or 2 per cent ichthyol ointment, soon relieves the condition.

In the intertriginous type occurring especially beneath the breasts, and in the crotch, painting with a 3 per cent solution of gentian violet is very efficient. When much inflammatory reaction is present, a preliminary treatment for several days may consist in soaking the parts twice daily with a hot solution of potassium permanganate in the strength of 1:2000, dressing the parts in the interim with an ointment containing 10 per cent naftalan.

In *Perlèche*, Finnerud found the local application of an 8 per cent solution of silver nitrate efficient. This application may be repeated at three or four day intervals. Prophylaxis is necessary in this condition when occurring in epidemics and consists in the use of individual drinking cups and towels, and careful sterilization of the utensils used by the patients, and also avoidance of direct contact.

### Contact Dermatitis

Dermatitis, presumably produced by external irritants, is among the commonest of cutaneous disorders for which patients seek relief. These cases cover a broad field, beginning with the simple dermatitis venenata group, produced by ivy, primrose, and so on, and ending in that large group of cases which may be termed trade or professional dermatitis or eczema. In the venenata type hypersensitiveness is usually specific and restricted to a single irritant, while in the second type, multiple sensitizations occur simultaneously or successively and there is in addition an unknown factor, operative in certain cases, which induces secondary eczematization.

The symptoms in all of these cases are sufficiently similar to be classed together. It is important, however, to be able to distinguish between them for the reason that dermatitis venenata is a comparatively simple affection running its course in a short time and does not recur unless contact with the same irritant is repeated, whereas the



other type may continue indefinitely through the development of new sensitizations. The recognition of either type is not difficult, but the discovery of the exciting irritant often presents a problem.

The number of substances capable of producing dermatitis by contact is endless. There are, however, certain ones that are responsible for the major portion of cases. Prominent among these are plants (ivy, primrose), animal proteins (hair, dandruff, feathers), and dyes, cosmetics, matches and chemicals.

A clue is sometimes suggested by the season of the year when the dermatitis develops and also by the areas of the cutaneous surface first attacked.

Ivy and ragweed dermatitis occur during the summer; primrose dermatitis at any season but often augmented at Eastertime when these plants are extensively distributed. In the autumn and early winter, dyes in furs become important. A dermatitis recurring on Monday suggests para-red used as a pigment in the rotogravure section of the Sunday paper.

The location on the skin is often suggestive of the nature of the irritant. When the dermatitis begins on the neck, the dye in the fur collar is suspected. When extending over the forehead from the scalp, hair lotions and dyes may be responsible. When patches are situated under the vest or trouser pocket of a man, matches are immediately incriminated. It is sesqui-sulphid of phosphorus that is the active agent in the last named cases.

Among the common irritants, in addition to the above, are: paraphenyldiamin, used in hair dyes and for dyeing fur. This substance is an excellent dye, producing a fixed black color, but has unusual irritating effects. Pyrogallol also is found in hair dyes, usually claimed to be walnut stain, and often produces dermatitis. Anilin dye in face powder and rouge and powdered orris root in face powder are common irritants. Toilet water containing bergamot may produce dermatitis and pigmentation upon exposure to the sun's rays (Berloch dermatitis). Various perfumes and perfumed cold cream, Lash Lure (an eyelash dye) and mascara (a dye).

Picric acid and butysin picrate, used in the treatment of burns, often produce a se-

vere dermatitis, which may be accompanied by general autointoxication.

Other irritants include: adhesive plaster, insect powder (pyrethrum), hexylresorcinol solution S. T. 37 (an antiseptic), novocaine and related substances, formalin, orthoform, metol (used by amateur photographers), lacquer (used on canes, Mah Jong sets and other articles). This preparation is manufactured from a Rhus varnish. Woods—coco-bolo, yew and numerous others; turpentine is a very common irritant due to its extensive use in house renovation. It is interesting to note that pyrethrum used in insect powder is a form of chrysanthemum. An epidemic of dermatitis produced by this chrysanthemum was reported recently by Sequire from Africa.

The clinical symptoms of the venenata type range from erythema to gangrene, depending upon the exciting factor. In the early stages there is an erythema limited to the area of contact. This is shortly followed by edema, swelling, vesiculation and crusting. Occasionally, secondary infection is indicated by pustulation. At times the dermatitis spreads beyond the demonstrable area of contact and may, through invasion of successive areas, continue to develop over a period of several weeks and over a large proportion of the cutaneous surface. In these cases the original irritant produces a severe local reaction in which toxic substances are formed that presumably induce the widespread eruption similar to the "id" eruptions from local infections seen in the mycotic diseases. In the major portion of these cases the dermatitis develops within 24 to 72 hours after contact with the irritant. In recurrent attacks, particularly in that form produced by primrose, ragweed and others, the inflammation may be subacute and resemble eczema. In these the lesions are erythematous-vesicular or erythematous-squamous and are accompanied by infiltration and sealing.

*Match or Match Box Dermatitis.*—This form of dermatitis was originally recognized by Rasch in Denmark. The affection begins on the thighs or on the side of the abdomen under the trouser or vest pocket where matches have been carried. In these areas there is a well defined patch of scaling dermatitis. Somewhat later the affec-

tion involves the face, lids, hands and other regions of the cutaneous surface. On the face the reaction may be so severe as to entirely close the eyes with the external edema and swelling.

Contact dermatitis furnishes a large number of cases eligible for compensation under the industrial compensation act. The determination in each individual case as to whether the articles contacted in the work are responsible for the dermatitis frequently presents a delicate problem for the physician. Foerster states that the majority of industrial dermatoses in this country are cases of contact dermatitis and are due to acids, alkalies, caustics, oils, greases and solvents. In Ohio, Schwartz found that the majority of industrial dermatoses have occurred in workers with oils and cutting compounds and in the rubber industries. It is well known that sensitization in many instances only develops after prolonged contact with certain substances, both chemical and plant, which fact adds to the difficulty of the solution of the problem. For example, a physician doing laboratory work may handle formaldehyde for years with impunity and then suddenly develop a sensitization to it which handicaps his further professional activity, and again sensitization to primrose has been developed through prolonged contact.

*Diagnosis.*—As stated above, it is apparent that the recognition of contact dermatitis is not difficult, but the discovery of the exciting agent often presents a problem. A careful search of all contacts with possible irritants is made and any articles suspected may be employed for cutaneous testing. The patch test originally described by Jadassohn and popularized by Bloch is the one employed in these cases. In this test the suspected substance is placed on a piece of linen and applied to the normal skin and this is covered with a piece of gutta percha tissue or oiled silk and held in place with adhesive plaster. It is removed after 24 hours. A positive reaction is indicated by a dermatitis of the nature of the one primarily exhibited. It may occur within a few hours or be delayed several days, depending upon the degree of hypersensitivity of the patient. The test should be ap-

plied as near as possible to the area of original dermatitis as a sensitization may be more or less restricted or localized. While this test is valuable as confirmatory evidence, a negative reaction does not necessarily prove that the suspected irritant is not the cause of the dermatitis.

In the dermatitis venenata type the antibodies are fixed to the epidermal cells, hence the P. K. passive transfer is not possible as there are no circulating antibodies.

*Treatment.*—The most important task is discovery of the irritant and its removal from contact with the patient. The treatment of the immediate attack consists of both local and internal applications and agents. An efficient method is the employment in the early stages of an aqua calcis lotion (sodium biborate, 10 gm.; amyllum, 15 gm.; zinc oxid, 15 gm.; liquor calcis, 120 gm.; aqua rosa q. s. ad., 240 gm.) several times during the day, alternated with the application of an oily cream such as the following: bismuth subnitrate, 4 gm.; zinc oxid, 8 gm.; olive oil, 120 gm.; liquor calcis q. s. ad., 240 gm. After two or three days, when the affection is less acute, the same preparations may be used during the day with an ointment containing naftalan or ichthyol over night (naftalan, 10 gm.; zinc oxid, 25 gm.; petrolatum q. s. ad., 100 gm. Ichthyol, 2 gm., may replace the naftalan in the above formula). In some instances where pyogenic infection has developed, a solution of aluminum subacetate or potassium permanganate may be necessary. The use of extracts of plants for immunizing and curative purposes varies with individual opinion. In ivy dermatitis Schamberg advised the internal administration of the tincture of *Rhus toxicodendron*, compounded as follows: Tincture *Rhus toxicodendron*, 1 gm.; alcohol, 5 gm.; syrup of orange q. s. ad., 100 gm. The preparation is given after each meal, beginning with the dosage of one drop, increasing one drop each dose to twenty-one, after which one teaspoonful is given once a day.

Immunizing injections are of value in some cases and may be employed both for immunizing and curative purposes. Brunsting found the use of ragweed oil of little value either as a preventive or curative



measure. A method of treatment of all types of contact dermatitis which has been of great value to the writer is the use of sodium thiosulphate. This is given by intravenous injections as follows: one-half gram the first day, one gram the second,

third, fifth and seventh days. This drug has the ability of overcoming hypersensitivity to a high degree. Cases that formerly extended over a period of several weeks commonly clear up in a week or ten days under its administration.

## TREATMENT OF FIBROID TUMORS AND BLEEDING OF THE MENOPAUSE\*

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In a discussion of the x-ray treatment of patients presenting themselves with symptoms of uterine bleeding, it would be extremely interesting to cover the entire subject, but because some of the newer applications, such as the treatment of the pituitary gland, in younger women is still in the experimental stage, and because we do not believe in, nor use, a temporary sterilization dose on younger women, this paper will be confined to patients of about forty years of age. They may either have menorrhagia or metrorrhagia (in which no pathologic lesions may be found upon examination), or a definite fibroid tumor with or without bleeding. Pa-

tients presenting themselves with the above symptoms, who after proper clinical examination reveal no gross ovarian pathology, obtain very satisfactory results with proper x-ray therapy. It seems logical to assume that neither surgery nor x-ray will be the ultimate treatment employed in these conditions, as it is our opinion that these are but symptoms of endocrine imbalance, and in the end endocrinologists will care for them.

Advances in medicine are slow. New methods are adopted only when sufficient experience has been accumulated to prove that the new form of therapy will irradicate the disease and cause less deviation from the normal than previous methods. Surgery is an older form of treatment than radiology, and has been established as the preferred treatment of both fibroids and bleeding. This leaves radiology in the position of proving its equality or superiority before it can be expected to be adopted as the preferred mode of treatment.

Let us begin by stating what surgery has to offer. In tumors of the uterine body, both carcinoma and fibroma, and in bleeding without these conditions (we include car-

cinoma of the body of the uterus because at times the most efficient examination fails to prove its presence), surgery, in removing the uterus, removes the pathology. It assures the patient that she will be relieved of her symptoms and, unless she has a carcinoma of the body of the uterus, she will remain well. In cancer of the body between fifty and sixty per cent will be cured. In many non-malignant cases, the ovarian function can be preserved. This at first glance appears to be a panacea, but at what costs are these results obtained?

### Operative Mortality

The question regarding whether a total or a sub-total hysterectomy should be done, when no known malignancy is present, is still a debatable one in surgical literature. We have no doubt that in most of the larger hospitals either a total hysterectomy or some form of operation that removes the mucosa of the cervix is done, but in the hands of many operators, total hysterectomy is not done because of the higher mortality. Published statistics for hysterectomy in some of the larger hospitals, such as St. Luke's in New York City, quoted by Wood, give an operative mortality of 1.5 per cent

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in one thousand cases. The Mayo Clinic reports for 1931, where 473 cases are reported, 287 total and 186 sub-total with eleven deaths or 2.3 per cent mortality. Many published reports establish these figures as correct for the best surgeons, but we have knowledge of hospitals where the mortality runs as high as five per cent. So we will grant that surgery removes the disease, but with a conservatively estimated mortality of over three per cent.

In many cases where the cervix is not removed we believe there is an additional mortality, the size of which we cannot compute, as there are no given statistics. This is the mortality that follows malignancy developing in the retained cervix. In a series of 150 cases of carcinoma of the cervix, we found 11.8 per cent were in retained cervixes. You may claim this is due to poor diagnosis, but these cases are from the average men in an average community. Five of these cases did develop the disease within the first year, showing definite lack of accurate diagnosis, but the remainder show periods varying from two to eighteen years before the carcinoma developed. The percentage of carcinoma in our series is very high, and is probably due to the small number of cases, but carcinoma of the retained cervix is a factor which can not be neglected when the mortality from any form of treatment is computed. No case in our series treated by x-ray has developed a carcinoma of the cervix and there has been no mortality from the treatment.

### Morbidity

Anyone observing a large group of cases after hysterectomy will admit that (barring the immediate mortality) the results are good. However, a certain number of these cases will develop definite sexual dysfunction. At times this may be due to defective surgery which causes mechanical difficulties. It is a serious complication when these results occur, because, if the ovaries are left in place, ungratified sex impulses can be very disastrous to the individual involved. Patients treated by irradiation, upon careful questioning as to sex function, reveal that there is little if any immediate change. Changes occur, but they are gradual and take several years to develop. While

this is not ideal, it more nearly approaches the normal physiological condition which occurs in women at this period.

Another form of morbidity following surgery and less frequently present after x-ray therapy, is the development of ovarian pathology, which necessitates subsequent surgery. The exact number of such cases is difficult to determine, but its occurrence must be acknowledged by all.

In all the discussions relative to the proper methods of treatment certain contraindications to the use of x-ray are mentioned, the most important of which is sarcomatous change in the fibroid tumor. There is great divergence of opinion in the literature as to the frequency of sarcoma of the uterus. Lynch showed 4.6 per cent present in 683 cases. Kaufman in his textbook on pathology says it is most common in the submucous type and quotes Evans as having found it in 1.8 per cent of 4,000 operative cases. Wood, after examining 1,000 cases, gives no percentage, but says it is rare.

The following is a quotation from Corscaden and Stout, 1929: "A very extensive résumé of the literature was made by Piquard in 1905. Between the years of 1857 and 1905 he collected reports on 127 cases of sarcomatous degeneration, including 5 of his own. In 103 of these the diagnosis was based upon morphological evidence alone. Of the remainder 4 must be discarded because of doubt as to whether they are sarcomata or carcinomata. Eight were found to have invaded surrounding structures. Fifteen recurred after removal and in 8 there was metastasis. Therefore, in this forty-eight year period, a compilation covering the literature of eight countries contains records of 31 proved malignant sarcomata of the uterus."

Four years later Kelly and Cullen, 1929, published another elaborate investigation. "Among over 1,400 myomata of the uterus there were 17 which they considered showing morphological evidence of being sarcomata. An analysis of these reports shows that there was proof of malignancy in but 7: *i.e.*, 2 recurred locally after hysterectomy; 3 showed apparent invasion of the neighboring tissues, and two had distant metastases. On the other hand, a few of the ten cases for which there exists nothing but



morphological evidence that they were sarcomata, have remained well several years after operation."

In 1920 the results at the Mayo Clinic were studied by Evans. He found that from 1906 to 1918 inclusive, a period of thirteen and a quarter years, there had been 4,000 operations for uterine fibromata. Seventy-two of these previously had been reported suspicious or malignant, but only eleven proved to be so, recurring locally and invading the peritoneal cavity. Using his criterion, only thirteen were histologically malignant. This gives us a figure of 0.39 per cent of all fibroids removed by operation in this series which were malignant. This corresponds very closely to the figure 0.5 per cent obtained by Kelly and Cullen of proved malignant neoplasms among the fibromyomata.

A few years ago it was common practice for pathologists and gynecologists to examine series of fibromyomata removed at operation for evidence of sarcomatous degeneration and the results were startling. Warner, in 1917, and Miller in 1913, found that about 2 per cent of all myomatous uteri showed sarcoma. Geist, in 1914, while examining 250 myomata, found that 4.8 per cent of them showed sarcomatous change. Spencer, discussing a presentation of 2 cases of sarcoma of the uterus by Andrews, 1921, stated that he had found sarcoma in 6 per cent of all cases of myoma, and that Bumm put the figure as high as 12 per cent. Because of this he now did total hysterectomy for myomata. All of these reports are based upon morphological changes and only in a few cases has any apparent attempt been made to discover what happened to the patient after she left the hospital.

If the observations of these writers are correct, a considerable number of women who have retained myomatous uteri are afflicted with sarcoma of the uterus. If this is a malignant neoplasm, we should be able to find autopsy records of such cases. In Bellevue Hospital, New York City, there are none recorded among the autopsy protocols, while there are only three cases at Presbyterian Hospital, New York City. At Boston City Hospital in 1917 there was recorded only one case, which was studied

by Gardner. He noted that of 827 myomas examined at the hospital, twenty-four were histologically malignant, but this was the only one in which the growth had metastasized. It may be argued that hysterectomy has cured many of these women, but if this is true, why have we such a dearth of autopsy records of women dying of sarcoma of the uterus in the days before hysterectomy for fibroma became such a common practice?

Corscaden and Stout's conclusions are: "One cannot escape the impression that, although an appreciable number of uteri may be found in which histological changes have occurred, exactly similar to or closely resembling the changes found in proved malignant neoplasms arising in fibromyomata, only a small proportion of these are actually malignant themselves. One cannot say what the proportion of malignant neoplasms among histological sarcomata of the uterus is, because seemingly no one has seen enough cases and allowed them sufficient length of time. Our impression is that the figures of Evans are very close to the truth and that only about two-fifths of one per cent of all fibromata are malignant."

The reason for these divergent opinions, of course, is not hard to find. The difficulty lies in determining exactly when malignancy has developed from the cell morphology alone. Ewing in his textbook makes the simple statement that diagnosis is difficult; so, with the number somewhere about 0.5 per cent of the observed cases, and the statement of Ewing that 50 per cent of all women over fifty years of age have these tumors, the facts bear out our experience that clinical sarcoma of the uterus is a rare disease. Nevertheless, it should be considered, and a rapidly growing tumor should be viewed with suspicion, but sarcoma of the uterus is not an indication for the use of surgery in uterine fibroid tumors.

Even granting that a proportion of cases are morphologically malignant, the type of x-ray therapy we use will be an added security. The patient will have had a course of pre-operative treatment, a procedure which is becoming more common, and which, we believe, will soon be routine in all malignant cases.

Another frequently mentioned contra-

indication is carcinoma of the body of the uterus. If the observation made by many writers that myoma occurs in 20 to 50 per cent of all women, the coincidence of the two conditions will of course be striking. However, we feel that careful diagnosis including curettage will exclude most of these cases, and a careful follow-up and knowledge of the subsequent course of a case after radiation therapy will eliminate most of the danger the patient might have from this source. If the patient is bleeding profusely, as many of them are, the radiation will control the hemorrhage so that the general condition of the patient improves. If surgery is necessary, the radiation given will form a valuable preoperative treatment.

Pelvic inflammatory disease was long considered a definite contraindication. Of late years, however, voluminous literature concerning the treatment of inflammation with x-ray has appeared. Tamdarow, in an article on "The Treatment of Fibroid Tumors" in *StrahlenTherapie*, gives pelvic inflammatory disease as one of the indications and says this condition disappears along with the tumor. Other European authors mention it and Desjardins, in *The Journal of the American Medical Association*, 1931, reviews the entire subject of x-ray treatment of inflammation. He refers to Gamberow, who treated 123 cases of adnexial disease with good results. Desjardins admits he is not sure of the mode of action of x-ray, but thinks it is on the lymphocytic infiltration. He adds that, after careful observation, he has never seen an inflammatory case made worse by treatment.

This has been our experience with cases of chronic pelvic inflammatory disease. It is our opinion that part of the good effects of radiation are due to a gradual reduction of the blood supply, both from the direct effect upon the infected tissue and from the results of the effect upon the ovary. That chronic pelvic inflammatory disease reacts favorably is particularly important, because it is in these chronically infected, adherent cases that most postoperative surgical accidents occur. The above does not apply to the use of radium. Radium is contraindicated, because of the intense local reaction it causes. No such reaction follows x-ray.

In all discussions the size of the tumor is mentioned as a further contraindication. Our experience has been, and we are sure that it has been the experience of all radiologists, that large size is no contraindication, for many times large tumors respond better than the small, dense variety. If the tumor contains calcified areas, these areas may be demonstrated roentgenologically before treatment, and in this instance surgery will be necessary, but in the greater number of cases this contraindication will not be present. Therefore, size has been disregarded by most men who treat these cases with satisfactory results. There is, however, a type of tumor, the large, slow-growing, irregularly nodular tumor, which reacts very slowly to x-ray. Usually cases of this type, which we have seen, have been associated with definite systemic disease, increased blood pressure, heart disease, or hyperthyroidism, and consequently the surgeon has hesitated to perform the grave, surgical manipulations necessary for its removal. As a result we have been called upon to treat a number of such cases. Some are accompanied by bleeding. The effects upon the bleeding have been excellent, but the tumors themselves have been slow to respond, and although we have followed a number of them over a period of years, we have yet to find one tumor that has entirely disappeared. Many have been reduced in size to a point where the patient is comfortable and the remaining tumor has no clinical significance. In our opinion this type of tumor (when it can be operated upon without too much risk) should be treated surgically.

This paper has been based entirely upon the use of x-ray in the treatment of these conditions. Radium, which produces excellent results in some cases, is definitely contraindicated when pelvic inflammatory disease is present due to its intense local reaction. In large tumors radium is likewise contraindicated, because anyone familiar with the physics of radium will readily see that little effect can be produced on the tumor itself, because radiation from radium is a form of light which varies inversely as the square of the distance, to which must be added tissue absorption.

The type of radiation used in these cases is a single series of 200 K. V. x-ray. It is



a rare occasion when we have had to repeat the treatment. It causes little or no effect upon the skin. In some cases the pubic hair disappears, but soon returns. The fields are so distributed that the radiation includes the entire pelvis. Many times we have heard it said that it is absolutely necessary to use radium for a quick cessation of the bleeding. We do not believe this, for we have seen patients with severe hemorrhage and marked anemia, cease to bleed following the application of one single dose of this type of roentgen-ray therapy. Following the above series of treatments, the patient may menstruate once at the normal time and there may be a small amount of bleeding at the second period. It is unusual to have more than this. If more bleeding occurs, immediate exhaustive search for other causative factors should be instituted.

Our results have been extremely favorable. The profession has been so impressed, that in our series 20 per cent of the cases are wives or close relatives of physicians. This treatment can be carried on frequently in an ambulatory manner. It requires no hospitalization unless the previous condition of the patient demands it. Excessive bleeding is usually controlled within a few days and the patient begins to gain strength. The percentage of disappearance of the tumors has been very high. It is, however, unreasonable to expect a tumor of large size or of marked consistency to disappear within a few days or weeks.

There is almost immediate cessation of the symptoms, but the tumor itself may remain for six to nine months before it entirely disappears. Occasionally, a tumor, not very large, nor of markedly hard consistency, will not totally disappear, but the patient's symptoms are alleviated and she is no worse than the thousands of women with small fibroid tumors who have never known the presence of the tumor. Careful follow-up of these cases must be the rule. Continuation of a discharge from inside the uterus, or return of bleeding, are serious symptoms, and if subsequent examination reveals that surgery is needed, the patient will be in better general condition to stand the operative procedure.

Let us summarize briefly the principal conclusions concerning the use of x-ray therapy in uterine bleeding, which we have attempted to elucidate by stating that:

1. Surgical results are good.
2. X-ray produces equally good results with less disturbance of the normal physiology.
3. X-ray therapy carries no mortality.
4. Many of the contraindications found in literature are not borne out by clinical experience.
5. Careful diagnosis is necessary.
6. This discussion applies only to the use of x-ray and not to radium.
7. The patients must approximate the age of the normal menopause.

#### **Picrotoxin in Treatment of Barbiturate Poisoning: Report of Case**

Edward M. Kline, Edward Bigg and H. A. K. Whitney, Ann Arbor, Mich. (*Journal A. M. A.*, July 31, 1937), before evaluating the therapeutic response to picrotoxin in their case of barbiturate poisoning, consider (1) the degree of poisoning, (2) the part played by the several other therapeutic measures and (3) the probabilities of recovery had not picrotoxin been employed. The 3 gm. of amytal ingested by the patient is, according to Sollmann, within the fatal dose range. He considers from 2 to 3 gm. as the amount usually fatal for man. This fact, coupled with the clinical picture of low blood pressure and absence of all reflexes, indicates that poisoning was severe. When many therapeutic measures are carried out concomitantly it is difficult to evaluate the effectiveness of any one. Other than picrotoxin, the significant procedures employed were strychnine,

gastric lavage and intravenous dextrose. Shock and prevention of dehydration were their indications for the administration of intravenous fluids. This, they feel, is an essential principle in the management of all poisonings. Some workers are of the opinion that intravenous fluids are of value as a vehicle in hastening the excretion of barbituric acid, while others maintain that its efficacy lies solely in its supportive nature. The importance of picrotoxin in the treatment of this patient must be weighed carefully, as recoveries do occur in severe cases when nothing more than general supportive measures are employed. Although it is impossible to conclude that the use of picrotoxin was a life-saving measure, the authors definitely feel that the recovery time was shortened. It should be emphasized that the use of picrotoxin is still in the experimental stage and that universal use must await further reports of its clinical application.

## CEREBRAL INJURY IN THE NEWBORN DUE TO ANOXIA AT BIRTH

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Kronig and Gaus, of Freiburg, Germany, nearly twenty-five years ago, introduced obstetrical analgesia into medical practice. It was immediately acclaimed by the profession in the world at large as a great humane advance in treating a very painful and exhausting ordeal. The method was soon given practical use in this country, but after a short and somewhat disastrous trial was largely abandoned. The danger to which the parturient mother and newborn child were subjected quickly became evident. Infant mortality increased at birth and more deeply narcotized mothers required instrumental delivery. The employment of obstetrical drug analgesia and amnesia quickly fell into disuse and disrepute because no scientific attempt was made at this early period in this country to study the basal metabolism, body weight and all other vital physiological factors entering into the final stages of labor.

The logical result of the crude and somewhat startling procedure of administering large doses of scopolamine and other powerful narcotic drugs to the woman in labor, whether she was in a hospital or about to be delivered in her own home, was to invite disaster. It is obvious, in the light of our present knowledge, that certain serious accidents were inevitable in the face of this unrestricted and unscientific practice. During the past few years there seems to be a re-awakening of the implications of so-called "painless childbirth." The publications of obstetricians and the laity have appeared with increasing frequency and have stressed the subject of dosage and the propriety of certain drugs employed to induce analgesia and amnesia in the expectant mother. The dangers to the newborn babe are considered and excellent articles explaining methods and apparatus for infant resuscitation at birth are offered, with, however, no adequate treatment of the subject of over-narcotization of the mother prior to delivery.

It is fundamentally important to deal with every woman in labor as an individual case in the same considered fashion that one proceeds with any serious operation. The complacent and uncritical use of any routine analgesic medication is bound to be fraught with danger, since the drug dosages employed are often beyond the range

of recognized pharmacological safety. We are convinced that this statement is substantiated by the startling lack of fundamental knowledge of the pharmacologic and experimental therapeutic action and dosage of those drugs which are so extensively employed in obstetrical work. When death of the newborn occurs, the cause is usually ascribed to asphyxia, pulmonary atelectasis and intracranial hemorrhage, although complete autopsy proof from examination of the whole body, including the brain, is often lacking. It is obvious that no cause of death is correct unless the proof is the result of a thorough investigation of the whole body of the infant, including microscopic tissue studies of the central nervous system by a competent neuropathologist.

Although the narcotic drugs employed in obstetrical practice are administered to the mother, they are capable of affecting the tissues of the child as well as those of the mother. The respiratory center is composed of highly sensitive nuclei. The effect of the narcotic drugs used is to depress the respiratory center and, if the depression reaches sufficient intensity, breathing ceases and a state of asphyxia ensues. To this state Barcroft has applied the term "Cerebral Anoxia."<sup>1</sup> "Nervous tissue is more sensitive to deprivation of oxygen than is any other tissue. Anoxemia of mild degree impairs its coördination. Even a short duration of asphyxia abolishes its functional activity. Complete anoxemia maintained even for ten minutes, or less acute for a longer time, may lead to irreparable damage to the nervous system."<sup>5</sup>

It is quite the habit in obstetrical practice to conduct a woman through labor



without pain or memory of the event. Subject to reasonable restrictions this is a commendable and scientific practice. We are not attacking pain reduction in childbirth, with the fortunate amnesia which is often concurrent, but we are proposing to show, by the clinical observations of one of us (Frederic Schreiber), that the use of strong narcotic agents may be associated with permanent brain changes in the living child.

Experimental evidence is not lacking to prove that cerebral asphyxia can result from insufficient oxygen content in the inspired atmosphere,<sup>5</sup> or after severe injury of the respiratory center in the medulla, from over narcotization of the patient.<sup>9</sup> When large doses of narcotic drugs are administered to a woman in labor over a short period of time, with the cumulative effect which is inevitable, the placental circulation carries these noxious agents into the central nervous system of the infant. The clinical evidence of asphyxia in the baby following delivery of a narcotized mother is well known. If the oxygen deprivation (cerebral anoxia) is of sufficient duration, irreparable brain damage results. The final clinical proof must come from a study of the neurological material under the microscope or the cerebral syndrome which develops within the first years of life, in which case the record affords conclusive evidence of narcotization at birth.

In the past five years we have had the opportunity to observe some three hundred cases which were diagnosed as "birth injuries," approximately half being seen because of convulsions, a fourth because of spasticity and the rest because of mental retardation. No matter what the history of the delivery in these cases—whether breech, precipitate or premature; spontaneous or with interference; with or without analgesia—the majority had one feature in common: a history of *respiratory embarrassment at birth as evidenced by difficulty in breathing, cyanosis or the necessity for resuscitation*.

It has long been known clinically that if the human organism is placed in an atmosphere deficient in oxygen for a sufficient length of time there may develop neurological symptoms pointing to permanent cerebral damage. In recent years two independ-

ent monographs have convincingly demonstrated the microscopic lesions produced in the human and animal brain following a sufficient exposure to a decreased oxygen supply. Yant<sup>10</sup> and his coworkers have demonstrated the definite cerebral lesions in animals exposed to oxygen deficient atmospheres. Courville,<sup>2</sup> approaching the problem from a different angle, demonstrates similar "devastation areas" or areas of patchy necrosis in cases where death has been delayed for some time following asphyxia. In cases of death from cerebral anoxia the early brain findings are those of stasis, thrombosis, perivascular edema and perivascular hemorrhage. If sufficient time for repair has taken place before death, the gross and microscopic findings are those of gliosis and atrophy.

The entire oxygen supply to the fetus is dependent on the mother and any oxygen deficiency to which the mother is exposed is registered in the highly sensitive vital centers of the fetus. Shutting off the necessary oxygen to the fetus is as disastrous as interfering with the air line of a deep sea diver. Whether the oxygen supply to the brain is shut off by mechanical pressure, by the thrombosis of a vessel, by actual oxygen deprivation or by a depression of the respiratory center, the ultimate cerebral damage must necessarily be the same.

As with any medical problem, in dealing with those cases diagnosed as "birth injuries," it is important to examine the past record which may possibly throw some light on the etiology. In reviewing the birth records in cases of "birth injury" seen by one of us and delivered in the past five years by two groups with which we have been associated, it was evident that almost without exception heavy analgesia had been employed in every case which came to us later, in spite of the fact that the use of deep analgesia during this period was not general in these groups. In all cases under consideration, the outlook for spontaneous delivery was regarded as normal at the onset of labor.

The principal drugs employed were morphine, scopolamine and barbituric acid derivatives such as sodium amytal, pentobarbital sodium, nembutal and dial, or combinations of these. There appeared to be gener-

ally routine doses. Scopolamine was used in this limited number of cases in much the same manner as in a series of almost five hundred consecutive cases reported in THE JOURNAL of the Michigan State Medical Society in October, 1933, from which we quote:

"The average dose of scopolamine was five 1/100 gr. The smallest dosage given which resulted in complete amnesia was two 1/100 gr. and the largest dose used in this series was twenty-one 1/100 gr. The twenty-one doses were used in a patient kept under scopolamine forty hours. She entered the hospital in labor Saturday and was delivered Monday. When she awoke she had lost a whole day."

The routine initial dose of the barbiturates appeared to be nembutal, grs. VI, plus gr. 1/100 of scopolamine. Although the toxicity of nembutal, grs. VI, equals that of sodium amytal, grs. XII, the latter drug was usually given only in IX grain doses.

Because the first toxic effect of both scopolamine and the barbiturates is to depress the respiratory center, the pharmacologist gives as the safe adult dose one much smaller than employed in obstetrical practice. Quoting from the latest 1937 edition of Sollman's pharmacology, the dose of scopolamine is given as 1/150 to 1/200 grain, "which may be cautiously repeated in six to eight hours." The author then goes on to warn of the danger of respiratory depression with small doses in individuals with special sensitivity to the drug. The pharmacologist also warns us that the first toxic effect of the barbiturate group is to depress the respiratory center. Sir William Willcox, in an article on the barbitone group in the *British Medical Journal*, March 10, 1934, states: "I have seen prolonged coma, suppression of urine and bronchopneumonia follow a normal dose by mouth of three grains of nembutal."

The clinical evidence that there may be depression of the respiratory center with the scopolamine or barbiturates used at birth is the more frequent need for resuscitation in the drug-born infant as compared with the undrugged infant.<sup>6</sup> Regardless of the specific drug employed to produce analgesia, it is the cerebral anoxia due to a drug depressed respiratory center which, in our

opinion, can reasonably be assumed to be the cause of disaster in some cases. It is, of course, obvious that every mother and infant do not show appreciable brain damage as a result of the large doses of analgesic drugs employed at birth. There are *certain variable factors*, however, which we believe may be responsible for the cerebral damage in some of the cases coming to our attention. We will discuss these under three theoretical heads: (1) metabolic anoxia; (2) anemic anoxia; (3) drug anoxia.

### Metabolic Anoxia

In this group there is an increased oxygen demand by the body tissues which cannot be adequately met owing to a depressed respiratory center. It has been found that for each degree of rise in body temperature there is more than a seven per cent increase in oxygen demand.<sup>3</sup> If for any reason the patient's temperature is elevated during delivery the oxygen demand is proportionately increased. Another reason for increased metabolism during labor is due to the increased muscular activity in the second stage. Knipping and Theodor<sup>7</sup> reported metabolic increases in the second stage up to 75 per cent. With the respiratory center depressed by drugs it is conceivable that the increased oxygen demand of the tissues cannot be satisfied by the available oxygen in circulation and asphyxial cerebral changes with subsequent brain necrosis may ensue. If the degree of cerebral asphyxia is severe enough at the time of birth the fetus may be stillborn. The following case is presented because of the autopsy findings.

*Case 1.*—A primipara, aged thirty-eight, was admitted in labor with a temperature 99° on admission.

The *Analgesia record* was as follows:

A.M.		
3:05	pulse 88	Scopolamine, gr. 1/100 Nembutal, grs. VI
3:30	pulse 92	
3:45		Scopolamine, gr. 1/100
4:15	pulse 116	Scopolamine, gr. 1/100
5:00	pulse 136	
5:15	pulse 156	
6:30	temperature 99°; pulse 128	
8:00	temperature 97.4°; pulse 100	Scopolamine, gr. 1/100
9:25		Scopolamine, gr. 1/200
10:20	the patient was conducted to birth room, where she was given nitrous oxide-oxygen-ether anesthesia.	

The baby was born dead. The fetal heart was normal at 9:00 a. m. The immediate postpartum (maternal) temperature was 103°, gradually returned to normal in seventeen days.

Autopsy of the brain showed a gross hyperemia. Dr. Louise Eisenhardt, the neuropathologist, after



preparing this tissue with special stains, reported: "The microscopical picture is typical of that described in cases of anoxemia, that is, a marked ischemic necrobiosis and extensive demyelination."

*Comment:* The difference between a living and a dead baby in this case is only chronological, since if the baby had survived it would, no doubt, have shown evidence of cerebral damage.

*Case 2.*—Multipara, aged forty, had an imbecile child seen at twenty-two months of age.

*Analgesia Record*

P.M.		
5:00	temperature 97.8°	Sodium allurate, grs. 10-1/2
		Scopolamine, gr. 1/100
5:30		Scopolamine, gr. 1/100
6:00		Scopolamine, gr. 1/100
9:07		Thymophysine, 1/2 c.c.
10:00		Scopolamine, gr. 1/100
11:25		Morphine, gr. 1/8
A.M.		Scopolamine, gr. 1/100
12:20	nitrous oxide-oxygen anesthesia was used.	
12:55	the baby was born with asphyxia pallida. The resuscitation was difficult.	

The immediate postpartum temperature of the baby was 102°, which rose to 104° at 8:00 a. m. and gradually returned to normal on the third day. The maternal postpartum temperature ranged to 102° over a number of days.

*Comment:* In both the foregoing cases there was a temperature rise noted before or immediately after delivery, which indicated an increased oxygen demand. It is well known that one of the first signs of serious cerebral anoxia is a rapid rise in temperature which accompanies cell necrosis.<sup>10</sup> A vicious circle may thus be set up with the tissues crying out vainly for more oxygen, being spurred on by a disorganized temperature center while the drugged respiratory center fails to meet the emergency.

Extrinsic temperatures may also have a part in the production of metabolic anoxia. On an unusually hot day in July, 1936, when the temperature reached 100°, several mothers and infants perished during labor with deep analgesia. One such case is recorded here with the suggestion that the unusual demand for oxygen due to the temperature rise from external heat could not be met by a drug depressed respiratory center.

*Case 3.*—Primipara, aged 26 years, was admitted in labor. Fetal heart heard in right lower quadrant. Temperature on admission 99.4°. Pulse 104; respirations 24.

*Analgesia Record*

P.M.		
3:10		Sodium amytal, grs. IX
		Scopolamine, gr. 1/150
4:25		Scopolamine, gr. 1/150
8:00	pulse 108	Scopolamine, gr. 1/150
9:40	temperature 104.4°	Pituitrin, min. III.

At ten o'clock p.m., the patient was transferred to the delivery room when her pulse was 140. She

was given nitrous oxide-oxygen-ether anesthesia when an easy breech extraction was performed. The baby was stillborn.

The temperature taken in the axilla immediately following delivery 108.8°. Pulse 160. The patient remained unconscious with a terminal temperature of 105° until death ten hours after delivery.

### Anemic Anoxia

In this group, the number of red blood corpuscles being depleted, there is a lack of oxygen and carbon dioxide carriers to the brain. The respiratory depression and blood stasis produced by analgesic drugs further deprive these carriers of the necessary oxygen, with resultant cerebral degeneration. An anemic mother may be a definite analgesic risk and it is possible that more "birth injuries" than we now appreciate are born of such narcotized anemic mothers, since anemias of pregnancy are not uncommon.

*Case 4.*—The patient, a primipara, aged thirty, was first observed in January: 40 per cent hemoglobin; 1,700,000 red blood cells. She was seven months pregnant when a transfusion of 500 c.c. was given. The fetal heart was normal. In February she was estimated eight months pregnant: the blood pressure, systolic 138, and diastolic 80; fifty-five per cent hemoglobin; 2,430,000 red blood cells. Medical induction was as follows: castor oil and quinine, Thymophysine, four minims every fifteen minutes for five doses.

P.M.		
10:24	Surgical induction. Membranes ruptured	
A.M.		
2:15	pulse 68	Sodium amytal, grs. VI
		Scopolamine, gr. 1/100
		Scopolamine, gr. 1/200
3:15		
4:00	fetal heart normal	
4:15	pulse 140	
4:30	fetal heart normal	

At 4:55 a. m., she was taken to the birth room and given 500 c.c. of 10 per cent glucose and 350 c.c. whole blood. The delivery was by low forceps and nitrous oxide-oxygen-ether anesthesia. The baby was born dead and showed asphyxia pallida. At 4:00 p. m., the temperature was 100.3°, the pulse 100, and the respirations 24. One month after the delivery, the hemoglobin was 45 per cent and there were 2,290,000 red blood cells.

*Comment.*—Although the greatest care was taken to insure a living baby in this desperate situation, the depressing effect of the analgesia employed may have been enough to tip the scales adversely. There was probably very little leeway between a living and a dead baby in this instance.

*Case 5.*—A boy, aged three and a half years, with spastic paraplegia and mental retardation. Encephalograms show a generalized atrophy. The following admission note was taken from the child's chart: "Mother not well since birth of child, very nervous, cries on slightest provocation, nightmares." The analgesia record is as follows: The mother was a primipara, aged 21 years. The temperature was normal, the pulse 90 and respirations 24 per minute.

A.M.	
4:15	Hysocine, gr. 1/100
4:45	Hysocine, gr. 1/100
5:15	Hysocine, gr. 1/100
7:15	pulse 118
8:00	temperature 99°; pulse 132; respirations 24
9:25	Hysocine, gr. 1/100
11:25	pulse 130
1:25	Hysocine, gr. 1/100
2:00	pulse 140; respirations 24
5:35	Morphine sulph. gr. 1/4

There was an easy forceps delivery under ether anesthesia. The baby was resuscitated with carbon dioxide-oxygen. One month later, the mother showed hemoglobin sixty-two per cent, red blood cells 3,420,000, and white blood cells 4,300.

*Comment.*—No blood count was taken in this case until an anemia was suspected almost a month postpartum. It is conceivable that such an anemia existed at the time of analgesic delivery, with a resulting anemic anoxia.

### Drug Anoxia

Idiosyncrasies for the barbiturates and scopolamine have been described and are not uncommon. Toxic effects have been noted from much smaller doses than those employed in producing birth analgesia.<sup>11</sup> Some such cases probably belong in this group. However, we include under this heading also those cases in which there is evidently no meeting of the minds between the obstetrician and the pharmacologist.

*Case 6.*—Infant aged three days. Generalized twitchings.

#### *Analgesia Record of Mother*

On admission mother's temperature was 98.4°; pulse 80; respirations 22.

P.M.	
8:10	Scopolamine, gr. 1/100
8:40	Scopolamine, gr. 1/100
9:10	Scopolamine, gr. 1/100
11:10	Scopolamine, gr. 1/100
A.M.	
2:20	Scopolamine, gr. 1/100
4:00	Scopolamine, gr. 1/100
6:00	Scopolamine, gr. 1/100
8:00	Scopolamine, gr. 1/100
10:00	Scopolamine, gr. 1/100
12:00	Scopolamine, gr. 1/100
P.M.	
2:00	Scopolamine, gr. 1/100
3:52	Ether anesthesia. Low forceps.

Weak cry. Immediate maternal postpartum temperature 100.8°.

### Effect on the Mother

The mother, as well as the child, may show evidence of brain damage associated with birth analgesia, both being equally exposed to cerebral anoxia if present. In one of the preceding cases the mother of the damaged infant began to have nightmares and crying spells, which continued for years after delivery. Psychiatrists have pointed out the increase in postpartum psychoses in recent years. In one series this marked in-

crease is attributed to the recent financial depression, but we would suspect respiratory depression may also be involved. In the following case the mother gives a history indicating organic brain change following delivery with sufficient analgesia to produce a blue baby.

*Case 7.*—Primipara, aged 26. The patient complains of frequent grand mal seizures since the birth of the baby. She had no previous seizures.

#### *Analgesia Record*

A.M.	
9:45	Scopolamine, gr. 1/100
10:15	Scopolamine, gr. 1/100
10:45	Scopolamine, gr. 1/100
P.M.	
12:45	Scopolamine, gr. 1/100
2:45	Scopolamine, gr. 1/100
5:03	The baby was delivered with low forceps. Ether.

The blue baby was resuscitated with oxygen by catheter.

### Encephalography in Cases of Suspected Analgesic Birth Injury

Encephalography has been employed in a considerable number of the cases in this series of "birth injuries" associated with deep analgesia. Brain atrophy, either generalized or unilateral, is a frequent finding. Such a generalized atrophy is shown in Figure 1 from a case of idiocy in which analgesia and forceps were employed.

The *analgesic record* of the mother follows:

A.M.	
11:00	Nembutal, grs. III
2:00	Nembutal, grs. 1-1/2
3:30	Morphine, gr. 1/6
5:00	Nembutal, grs. 1-1/2
5:40	Morphine, gr. 1/6
8:38	Ether. Forceps delivery.

The baby was born cyanotic.

Figure 2 illustrates a unilateral atrophy in a child with right-sided spasticity. The appearance is that produced by a thrombosis of a cerebral vessel, the stage being set for such an accident by the cerebrovascular stasis and anoxia secondary to respiratory depression.

The *analgesia record* of the primiparous mother was as follows:

A.M.	
12:25	Sodium amytal, grs. IX
	Scopolamine, gr. 1/100
1:15	Scopolamine, gr. 1/100
1:50	Morphine, gr. 1/4
	Scopolamine, gr. 1/100
5:00	Scopolamine, gr. 1/100
7:55	Scopolamine, gr. 1/100
8:14	Thymophysine, 1/2 c.c.
9:00	Nitrous oxide-oxygen-ether anesthesia. Easy forceps delivery.

The question of analgesia cannot be separated from the question of interference; the two go hand in hand. Although forceps



were necessary in almost every case in this series of damaged babies born with deep analgesia, the instrumental delivery was not thought difficult at the time. The adjectives,

these cases of birth injury are scattered among the orthopedists, neurologists, ophthalmologists, otologists, psychiatrists, speech experts and others, with the result

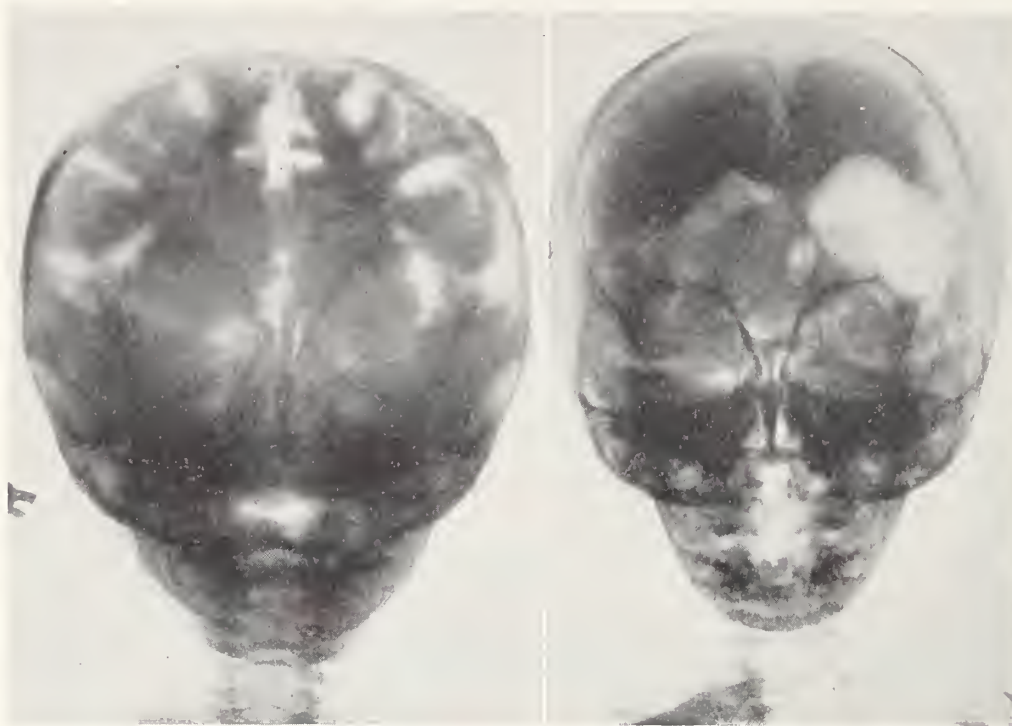


Fig. 1 (left). Antero-posterior encephalogram showing generalized encephalopathy.  
Fig. 2 (right). Encephalogram showing unilateral encephalopathy.

low, easy, academic and prophylactic, are used in describing the procedures. We have always felt that the relatively rapid molding of the head with forceps delivery or version simulated the hazards of the precipitate delivery, but that is aside from the subject of this paper. Today an interference rate of 70 to 80 per cent is acceptable in local obstetrical practice. These figures are given merely to show the increase in interference which analgesia as employed today has brought about. If painless delivery is possible with no danger to mother or child, it would be, of course, the method of choice. However, if there are dangers in such methods of analgesia plus interference, we believe the mother should be warned so that she may share the responsibility with her obstetrician when she demands a painless delivery.

The cases studied in our series of birth injuries were those desperate cases which come to the attention of the neurological surgeon. That lesser brain damage may result from cerebral anoxia at birth is probable. The newborn infant is handed over to the pediatricist, who in turn sends the baby to various specialists if the child develops mental or motor abnormalities. In this way

that the full extent of the problem is not apparent in any one medical specialty. In conclusion, even if an infant's brain were only damaged to the extent of producing a "problem child," as a result of cerebral anoxia secondary to birth analgesia, we believe the drug hazard to be sufficiently grave to warrant critical scrutiny.

#### Summary

1. Cerebral anoxia at birth with resulting permanent brain damage is proposed as an etiological factor in cases diagnosed as "birth injuries" of the brain.

2. The use of analgesic drugs employed in labor is discussed in relation to *metabolic anoxia*, *anemic anoxia* and *drug anoxia*.

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## PROBLEMS OF THE NEWER OBSTETRICS\*

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In discussing the problems of the "Newer Obstetrics" we do not intend to take a one-sided stand for or against either the conservative or the active school of obstetric practice. We simply wish to point out that in the evolution of obstetric practice certain new problems have been created which will require solution before the value of the newer obstetrics can be definitely accepted.

Obstetrics is by heritage conservative. Obstetrics is traditionally conservative. Labor and delivery have long been looked upon as physiologic processes, and in most cases are safe when allowed to follow an unmolested normal course. In accepting this viewpoint it meant that usually the attendant was necessary mainly to give moral and psychic support, and his chief function was to recognize complications, and to repair and lessen the damage that occurred in this normal physiologic process. The fact that most cases were normal led to this practice often being assumed by individuals who knew very little of what was happening during the process of labor. Thus midwives and untrained attendants from time immemorial had engaged in this practice. And doubtless the reason why these untrained attendants seemed to successful was because nature was kind and usually performed routinely, and the attendants comforted the patient though often they themselves knew very little of what was happening. In all medical practice we often get praise when nature does a thing well, and as medical men we often accept this praise, unconsciously, perhaps, to offset the criticism we may receive in spite of occasionally doing a good piece of work. So midwives and untrained attendants often received credit beyond their deserts, simply because nature worked well. When a complication existed which no one recognized, it was just unfortunate for the patient. Medical literature shows that the science of obstetrics did not advance until medical men overcame the reluctance of society in having a male attendant present at delivery. This dates back to the seventeenth century. And we have no record of what happened prior to that. Although most women had delivered themselves normally and survived, we have no record of what happened to those who had abnormal conditions, and it is no doubt

safe to assume that of those who were unfortunate to have complications many succumbed without anyone knowing what was wrong. There is no doubt that there is need for a great deal of intelligence in the practice of obstetrics, even though the process of delivery is considered physiologic, and no branch of medicine requires more trained intelligence and judgment. Furthermore, in no branch of medicine can the results of improper judgment be more grave.

Medical men then have had a great influence on obstetric practice and have tried to study the process of labor and delivery, and as the study developed it became evident that certain deviations from the usual could occur, and these came to be recognized as complications and abnormalities.

The medical literature of the seventeenth century is full of interesting reports of what medical men observed and learned. Here we have the first observations on deformed pelves, placenta previas, abnormal presentations, with descriptions of internal podalic version, and maneuvers for the delivery of the after-coming head, and the introduction of the obstetric forceps. With the increasing interest of medical men we also see the beginning of lying-in hospitals. One could go on indefinitely into medical history if time permitted. Medical men have been students, they have been inquisitive, and resourceful, and they have shown a great deal of ingenuity in trying to correct abnormalities. For a couple of centuries after medical men began to practice obstetrics they continued the conservatism as practiced by early midwives. As medical knowledge of obstetrics advanced, this knowledge was applied mainly to correct and overcome abnormalities. The medical man's field was to observe, and assist na-

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ture. The midwife in the past had watched and waited in blissful ignorance as to whether conditions were normal or abnormal. The medical man adopted the policy of watchful waiting more fully awake to conditions, and confident, in most cases, as to what conditions were. But the physician assisted nature only when conditions were abnormal, and when prospect for a spontaneous ending was either long delayed or absolutely impossible.

This type of practice was quite standard and the rule until about two decades ago. It is true that certain men departed from this conservative practice and often hurried labor for their own convenience, at times attempting delivery even in spite of the difficulty of an incompletely dilated cervix. This type of practice has been dubbed as "meddlesome midwifery," and it is condemned by all conscientious men. This was the practice only of the unscrupulous who considered himself first and his patient last, or not at all.

During the past two or three decades there have been marked changes in obstetric practice. These changes are proposed not by unscrupulous and indifferent practitioners, but have been suggested by some of our leading obstetricians. They view labor not as a normal physiologic process, but rather as pathologic. They point out that the normal physiologic processes of the body are not associated with so much trouble or pain, and do not go awry so often. They feel that the idea of watchful expectancy has much in it to be criticized, and they point out that normal physiologic labor so-called can be productive of a great deal of harm to both mother and child. Also, it is pointed out that the pain of labor has a very nerve-racking effect on the patient, and a prolonged second stage may result in irreparable damage to both mother and child.

These men, then, leaders in obstetric circles, are suggesting that the trained obstetrician can do a great deal to prevent damage to both mother and child, and can do much to diminish the amount of pain and shorten the period of suffering. Let it be emphasized again that these proposals came from some of our leading obstetricians, and we must at least give them credit for being sincere and honest in their convictions. No matter what our attitude toward this newer

obstetrics we must admit that this is a sincere effort on the part of these leaders to attempt to solve the pain of labor and lessen the suffering.

The medical profession was rather startled in 1920, when DeLee wrote his initial paper on "Prophylactic Forceps." This term was applied to a group of procedures which included not only a forcep delivery when the head appeared on the perineum, but preceded this with the administration of some pain-relieving drug during the first stage of labor. Included with the actual delivery was the performing of an episiotomy, and an early removal of the placenta. In the opinion of men like DeLee this compound procedure not only lessened suffering, but prevented a great deal of drain on the patient's strength, and lessened the strain on the nervous system, and left the patient in so much better condition that her post-partum recovery was hastened and more complete.

In the original paper on "Prophylactic Forceps" it was definitely pointed out that this procedure was safe only in expert hands, and that unless one was well trained watchful expectancy would still be the safer method. This immediately created two types of obstetric practice, and that in itself is a great problem of great importance.

Who shall decide what type of obstetrics a medical man should practice? Shall a man grade himself and decide on his own expertness? Look in the directory of the American Medical Association and note how many men have listed themselves as obstetricians. When a student graduates from medical school his diploma may specifically mention that he is qualified to practice obstetrics. His state license to practice confers on him that same legal qualification. If he then has the legal right to practice obstetrics, who shall say as to what type of practice he shall follow, and what procedures he shall be allowed to perform. Let us remember that every physician is also licensed to practice surgery. We would not expect every physician to delve into major surgery simply because he has a legal license to do so. Only his own conscience can be his guide, and the developing of an obstetric conscience should be the most important part of a practitioners' equipment for the practice of obstetrics. Fortunate are the patients of a physician who knows

his limitations. The development of an obstetric conscience, and the recognition of one's limitations are important factors in the safe practice of obstetrics.

In examining the statistics of the newer obstetrics we must conclude there can be no criticism of the results obtained by men who proposed these measures. They set out to relieve the suffering of labor, to shorten the period of suffering, and one must admit that they accomplished these aims with no added harm to either mother or child. But, on the other hand, we note the study of maternal mortalities made by the Academy of Medicine in the City of New York, and their direct conclusion is that the failure to reduce maternal mortalities has been due to the increasing amount of operative interference with normal labor. They conclude that the better results that might have been expected from improved facilities provided by Maternity Hospitals has been offset by the harm resulting from the increasing number of operative deliveries. One can only conclude that this is the result of having two standards of obstetric practice. The proponents of the newer obstetrics have shown how it can be done, but their procedures have been imitated by those less trained, and the result at large has been unsatisfactory.

This is the chief criticism that is heaped on the newer obstetrics. The general practitioner has always been, and doubtless always will be, the obstetrician for the masses. For every patient delivered by a trained expert, scores will be delivered by those less trained. The proponents of the newer obstetrics feel that the plane of obstetrics should not necessarily be kept down to the level of those less experienced. It is asked, "In what department of medicine is it not true that there is a great difference in results as to whether any procedure is performed by an expert or by one less trained? And the more major the procedure the greater difference will there be in the results. And what field of medicine and surgery would have made progress if all procedures were limited to those that the lesser trained could perform? And where would suffering humanity be if the dictum were made that no procedures should be attempted except what a lesser trained person could perform. Where then would

there be a place for ingenuity and skill in the practice of medicine?

If certain physicians develop a high degree of skill and can be of aid to suffering patients, without endangering the lives and health of mother and child, must they refrain from exercising this skill and offering this aid simply because some less trained person may attempt to imitate them? When this criticism is made, is it not viewing the problem from the wrong angle? Apply that same criticism to any field of medicine and what is the answer? Should not the responsibility be with the less trained? Should not he recognize his limitations and practice within these limits? And if he wishes to practice on a different plane, should he not qualify himself by the necessary period of training? Development of a conscience, and recognition of one's limitations, are requisite for safe practice in any field of medicine. The general practitioner will always be the obstetrician for the masses, and his results will always be satisfactory if he will adhere to the conservative principles taught in his medical school. He should have no quarrel with the expert who can practice a more radical obstetrics and still obtain good results. Obstetrics will always be the general practitioner's field as long as he retains his conservatism.

In reflecting on the changes that have occurred in obstetric practice, one realizes that slowly but surely obstetrics has changed. We may not like the change, but we cannot deny that there is a change. Even among those who are not devotees of the newer obstetrics, there has been a change of practice, a change of viewpoint. Often we find that certain men have their pet types of radicalism which they do not recognize as being radical. So it is evident that men may become radical along one phase of obstetric procedure without embracing all the ideas of the newer obstetrics. It is our purpose to review certain of these procedures.

One of the first types of active interference that became popular was the adoption of episiotomy in delivery of primipara. The reason for this, no doubt, was the unsatisfactory results often obtained from repair of lacerations. Nearly every one practicing obstetrics has been surprised at certain unsatisfactory results thus obtained. Different methods have been devised to prevent



lacerations, and often the physician would congratulate himself on delivering a patient apparently without laceration, only to be chagrined later to find how extensive the relaxation of the vaginal outlet could be in such a case. It became apparent that the delivery supposedly free from lacerations, was free only from visible lacerations. And from the resulting relaxation in some of these cases it was inferred that there had been muscle damage even though the mucosa had been left unlacerated. Naturally there was no way to determine such damage when the unbroken mucosa prevented visualization of the underlying muscle. The fact that results from lacerations (or from no lacerations) were so unsatisfactory led a great many practitioners to adopt episiotomy as a substitute. These men preferred a frank incision which was clean cut to either a ragged laceration, or an invisible laceration. This really was the application of surgical procedures to obstetrics. Many men soon found the results of episiotomy disappointing because they were not equipped to handle this like a surgical operation. But experience has shown that this is essential. It involves first of all a better preparation of the patient, in fact, a surgical preparation. Slipshod preparation is not adequate here. Second, it involves a surgical anesthetic. While a physician can often place a few sutures in a lacerated perineum without much anesthesia, it would be practically impossible to repair an episiotomy satisfactorily without an adequate anesthetic. A few drops of ether do not suffice here. Thirdly, a deliberate incision requires surgical asepsis for proper healing. This really means that episiotomy should be only a hospital procedure. The performing of an episiotomy outside of a hospital would necessitate a much better equipment than is usually available in a home delivery. These are some of the requisites for adoption of episiotomy in obstetric practice. A broken down episiotomy usually gives a worse result than a poorly healed laceration. Added to the above mentioned requisites is the fact that considerable surgical technic is involved in the repair of an episiotomy, and surely should not be undertaken by one unaccustomed to handling repair instruments, or by one who did not have a definite technic of repair in mind. Unless one has all these advantages at his

disposal, his results will be better if he allows his patients to deliver with laceration, and then repair as best as he can. The damage then, at least, will not be of his own making. Given good surgical conditions there is no doubt that the experienced operator can leave his patients in better condition by performing episiotomy than by allowing them to lacerate. Another feature not to be forgotten is that the performing of an episiotomy allows a shortening of the second stage and saves the fetal head from a great deal of possible trauma.

Another form of radicalism that has crept into obstetrics is the frequent induction of labor. The newest method for this is the artificial rupture of the amniotic sac. When for some indication induction is essential, rupture of the membranes is, in most cases, a simple and satisfactory method. The fear obstetricians formerly had concerning dry-labor was probably unwarranted. However, the attendant should realize that induction of labor is still something that requires great judgment. Its chief indication is in the toxemias when not to deliver the patient may be disastrous. One should always remember that the risk involved, although slight, is quite positive, and this risk should be undertaken only when a greater risk is thereby avoided. For this reason inductions for trivial reasons, inductions for convenience, should be considered with great reluctance. It requires real ability to diagnose the term of pregnancy, and one is greatly chagrined to induce labor for a supposedly overtime pregnancy, and then have a premature baby. And since such induction in cases of breech presentation is so disastrous for the fetus it presupposes the ability to make a correct diagnosis of presentation and position. Complications following induction of labor require a great deal of explanation, and the burden usually rests with the attendant. Induction of labor has a definite place in obstetric practice, but it is a procedure that should not be undertaken without definite indications. Judgment, based on experience, is essential in making this decision.

Still another radicalism of present-day obstetrics is the widening of indications for cesarean section. While this is at times justified, especially when the complication to be overcome is accompanied by very se-

rious possibilities, it must be remembered that cesarean section is not a simple cure-all. It is often stated that the more skilled the obstetrician, the less often need he resort to cesarean section. And in the hands of untrained men, a cesarean section may be more serious than the dangerous complication it is intended to avert. A lesson that the profession must still learn and comprehend more fully is that a cesarean section is a safe operation only if the patient is uncontaminated, and this refers not only to vaginal examinations, or attempts at vaginal delivery, but also has reference to the length of labor and the period of rupture of the membranes. And when one advises a cesarean section for a temporary indication it must be remembered that the cesarean section itself may then become a permanent indication. When one is told that cesarean section is so simple and safe an operation, let us remember that such operations cause a large percentage of the maternal mortalities in this country.

No doubt the most common type of radicalism that has crept into obstetrics is the increased percentage of interference with normal delivery. In fact, many men think only of this when radicalism is discussed. One cannot but feel that the advocates of the newer obstetrics should be credited with this dubious change. In former days the obstetric forceps was used only after conservatism had been exhausted. Formerly a forceps operation meant that in the opinion of the physician the labor could not be prolonged without harm to either mother or child. If delay for an hour would mean safe spontaneous delivery, then one just waited. But gradually the permissibility for use of forceps has been broadened, and now many a physician shortens labor when he feels the instrumental delivery will be an easy delivery. While it is true that in many cases the results seem as satisfactory as in spontaneous delivery, yet there are many cases on record where one can believe that conservatism would have been the safer plan. If these forceps operations were confined to those cases where the head was on the perineum and definitely crowning, the results might be quite satisfactory. But too often the physician is so emboldened by his success and the ease with which he can deliver these patients, that unconsciously he extends these operations to those cases

where the presenting part is not yet crowning. He is likely to forget what normal labor can accomplish and is likely to have the belief that these cases would never deliver if not aided. There is no doubt that the attendant's judgment becomes easily warped, and he forgets or is blinded to all he learned during his conservative practice. While many physicians with good facilities can perform these forceps deliveries with apparent safety, yet we must recall that in the study of maternal deaths made by the Academy of Medicine of New York, the conclusion was reached that the failure to reduce maternal mortalities was due to the fact that the better results that had been hoped for because of improved hospital conditions, had been offset by the harm caused by the increased number of operative deliveries. DeLee has called attention to the fact that results depend not so much on the forceps as it does on the man handling the forceps. Every physician should search his own mind and establish his own conscience. Every physician who practices obstetrics should develop a sensitive obstetric conscience, and should know his own limitations and should practice within these limitations. It would seem that the very fact that we have better hospital facilities has encouraged some physicians to be more radical. The protection of the hospital encourages them to attempt procedures they would not undertake in a home. If a hospital has this effect on a physician then it would be better for these patients to be delivered at home. It is this change in practice that has given rise to the viewpoint that patients can be more safely delivered at home than in the hospital. The only solution for this is the development of a keener and more sensitive obstetric conscience. In no field of medicine is this more important than in obstetrics. Faulty judgment may often be responsible for poor results. This can be pardoned if this judgment is arrived at after conscientious consideration, and the patient's welfare was the only consideration. To err is human and the physician is quite human.

We have heard much discussion about "meddlesome midwifery." This term seems to have a great many meanings. The term is intended to be derogatory and its chief application is to those attempts at delivery at a stage now universally recognized as



contraindicated. This, to put it plainly, refers to attempts at delivery before complete dilation of the cervix. It is strange that this type of obstetric practice still exists. It receives universal condemnation, but still persists. The only explanation can be the ignorance or the lack of conscience on the part of the practitioner. Fortunately, this is not a common practice, and physicians in general are quite unanimous in condemning it.

A great problem faces obstetricians in the efforts to lessen the pain of labor. This problem at present is undergoing a great deal of study and investigation, and all are agreed that it is not yet solved.

The suggestion of pain-relief during labor is greeted with antagonism from many quarters. For some reason or other even many physicians meet the suggestion with opposition. It is true that since the popularizing in lay magazines of the *Twilight Sleep* of Kronig and Gauss, popular demand has been created. Those who are antagonistic to pain relief in childbirth chide obstetricians for succumbing to lay demand and seeking to appease patients by relieving pain. This view of the situation is hardly correct for obstetricians of their own accord are interested in relieving pain of labor. Has not the medical profession, from time immemorial, tried to relieve human suffering? Has the medical profession evidenced signs of weakness just because they have in times past tried to relieve this suffering? After all is that not the chief aim of the profession?

A great many drugs have recently been developed to relieve the pain of the first stage of labor. These are too numerous to mention in this discussion. And it is safe to say that there is hardly a clinic or hospital where some clinical observation of this type is not being made, and each clinic is working out some method of pain-relief. The fact that such a variety of drugs are used is an evidence that no one drug is as yet greatly superior to others. The requisite for any drug is, of course, the fact that it must relieve the pain of labor with safety to mother and child. This is the problem that still confronts the medical profession. The drug that lessens pain must not interfere with progress of labor. Many of the drugs used at present while they produce a satisfactory analgesia and amnesia, cause

a great restlessness during labor. The handling of these patients is indeed a problem, and is a great tax on hospital attendants. This phase alone would preclude the use of these drugs in a home. There is no known way to enable one to anticipate which drug will cause this restlessness, or what patient will react thus. This restlessness may be so violent that an orderly aseptic delivery is almost out of the question, and about the only solution for this is a general anesthetic with the final delivery by a forceps operation. Not only is it often necessary to affect final delivery by forceps because of the restlessness, but the instrumental delivery becomes essential because in so many patients an inertia develops during the second stage. A great danger here is that the old abuse of pituitary extract may again be revived. In most hospitals the use of analgesic methods have been accompanied by an increased number of operative deliveries. This demands that the physician administering these pain relieving drugs must be equipped by training to accept this additional interference with safety. If these methods are employed it is evident that obstetrics will become more and more a major practice, and to practice this type of obstetrics with safety will require more and more training on the part of physicians. There is no doubt that in using analgesia to lessen pain of labor a serious new problem has been created, and it will require all the experience and best judgment of the practitioner to cope with the situations. At no time in the history of medicine was judgment more essential in the practice of obstetrics. Time only will disclose what the final solution will be.

An important phase of this application of analgesia to obstetrics is the effect on the baby. There is no doubt that the babies become partially narcotized, and as a result are slower to breathe, and require more efforts at resuscitation. The general feeling among obstetricians has been that once resuscitated, these babies were normal and pursued a normal course.

Our complacency in this matter was somewhat shaken by the opinion and work of Schreiber who concludes in his work as a brain surgeon that the baby's brain is damaged by the anoxia that occurs as a result of the drugs used. Obstetricians in general have not accepted these conclusions, but

Schreiber has at least called attention to a possible danger where obstetricians thought none existed. There is no doubt that when first used, these drugs were given in larger doses than necessary, and as dosage is reduced it is found that equally satisfactory analgesia can be obtained. Obstetricians feel that patients must not be informed that labor will be painless. Patients should understand that labor should progress up to a certain point before analgesia is given, and that relief may be given during the worst period of pain. In this way one dose of the analgesic drug is usually sufficient, and the baby will be less likely to show the effect of the drug used.

Obstetrics is at the cross-roads. Which direction will it take? The work in obstetrics is assuming more and more a major trend. Every new advance brings with it new problems. All advances are not unmixed blessings. These new problems require increasingly more skill in their solution, and the burden lies with the medical profession. To meet these new problems will test the judgment and skill of the practitioners, and this will require more and better training of all physicians. Only through better training can the new problems be met and solved.

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## LEGAL ASPECTS OF PSYCHIATRY\*

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It is of immediate importance to the sound development, both of law and psychiatry, that common ground be found where the members of both professions may meet, exchange knowledge and experience, and work out solutions for problems which are troubling the state and sorely vexing individuals, and for which neither profession has been able to offer anything but a half-way solution. In unison a complete remedy might be formulated; at least we may be sure that the most practicable program will be produced through concerted action. These two professions, both of whom can justify their existence only by real service for individual and public welfare, have been held apart by misunderstanding and distrust. Instead of cordial team-play, there has been a tendency to pull apart until the phrases "legal viewpoint" and "psychiatric viewpoint" have become nearly opposites. All this is unnecessary. A few rare spirits have soared above the fogs of argument and have seen the true objective.

The first step is to make medical men, especially those in the psychiatric field, fully conscious of the extent, limits, purpose, operation and crystallized experiences of our existing legal system, and to make lawyers fully aware of the content, scope and limitations of the psychiatric field.

Psychiatry is concerned with the developmental forces and processes and the clinical manifestations both of morbid inner experiences and of such outward behavior as interferes with one's social adjustments. Psychiatry is thus not confined to an inves-

tigation of disturbed brain physiology or of psychological processes arbitrarily removed from the real unity of experience of the individual, but is primarily concerned with the behavior of the human organism as a unitary system engaged in adjustment to its environment, between both of which there is a dynamic interplay. From this point of view, one sees that psychiatry is fundamentally a branch of biology. To the psychiatrist both mind and body are but abstractions, the concrete fact being the living organism. The behavior of the organism cannot be explained as the algebraic sum of the functions of the component organism, but we consider the human personality as a unity which includes both organism and the interplay with the environment. So much for the definition as to the concept of psychiatry.

Lord Chief Justice Coleridge, speaking in England in 1888 said, "The law in the matter of insanity is not incapable of being so interpreted as to do terrible injustice."

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Criminal responsibility is an elusive, fluid thing. One cannot dogmatize on it or lay down rigid definitions which are to last for all time. This suggestion the lawyer may reject, on the grounds that psychopathological thought is a fluid thing, changing from day to day, with the result that a criminal held responsible today may be deemed irresponsible tomorrow, and that the doctors, themselves, disagree among themselves and not infrequently contradict each other on the same witness stand during the same trial. The result is deadlock. Lawyers, regarding irresponsibility as a disorder of the intellect, demand that the boundary line between responsibility and irresponsibility shall be clearly defined. Medical science, regarding irresponsibility as a disorder of the emotions, insists that no definable boundary line exists. There are judges who welcome the most detailed and comprehensive medical evidence, not only with regard to the accused's mental poise during the medical examination, but concerning his mentality at the moment of the act. Others tend to beam with patronizing condescension upon the psychiatrist as if tactfully tolerating the eccentricities of a crank, while others regard him as a hired perjurer, retained for the purpose of ridiculing the obsolete machinery of the law. As a result, the unfortunate doctor who is called as a witness does not know what is required of him.

The war which is perpetually being waged between psychiatrists and lawyers upon the question of criminal responsibility will probably never come to an end. As Dr. Havelock Ellis has so clearly indicated, "our courts of justice are still pervaded by the barbaric notion of a duel. We arrange a brilliant tournament, and are interested not so much in the investigation of truth as in the question of who will win." Attempts to achieve peace have been made by suggesting the adoption of a compromise, the terms of which are that while medical men must forbear from demanding that lawyers should abandon their ancient axiom that a criminal may only be regarded as irresponsible through his ignorance of moral right and wrong, the lawyers must, on their part, concede upon the bearing of the latest achievements in psychopathology.

There are many definitions and tests of

responsibility. It has been suggested that if you are to class a criminal as responsible, you must prove that he "willed" the crime, intended the consequences of his act and sought to benefit himself by the crime, and that the criminal knew and appreciated the conditions under which he committed his crime. If any one of these considerations were absent, responsibility could be assumed to be impaired or nonexistent. The French Penal Code enacts that "there can be no crime or offense if the accused was in a state of madness at the time of the act," and the Statutes of the State of New York affirm that "no act done by a person in a state of insanity can be punished as an offense."

There is a growing assumption on behavioristic grounds that there is doubt as to the sanity of all murderers. Some morbid mental process, they reason, must be operating in the mind of a murderer, otherwise he would not murder. They base their view, not without logic, on the fact, well known to psychopathologists, that large numbers of people go through life tormented by a vague impulse to kill. From time to time a test is suggested which will definitely constitute the criterion of criminal responsibility, but they have invariably been rejected after consideration. There are some who consider as criminally irresponsible any man who is certifiably insane. But insanity is normally the exaggeration of only one function of the brain, and to bracket as equally irresponsible for the crime of murder the madman who kills his brother under the genuine delusion that the latter has entered his bedroom with the object of killing him (the madman), and the harmless hermit, whose only desire is to be alone, would be absurd.

While the views of conflicting schools of psychology may carry little weight at criminal trials, it is true that facts, indisputable facts, do sway judges and juries. Facts are evidence. If it is shown on behalf of an accused person, that he, or a blood relation, has at any time manifested the symptoms which we associate with borderline cases, the witness who produces such facts as evidence is addressing the court in understandable language. The attitude of the law towards criminal responsibility may be defined, roughly, as far as I am able to deter-

mine, as follows: "An accused person is not responsible for a crime committed when he was prevented by mental defect from distinguishing moral right from moral wrong at the moment of the crime, or from grasping the moral significance of the crime." Judges in practice may tend to accept proof of such mental defect *immediately* prior to a crime as implying continuance of that mental defect up to and including the moment of the crime. Ability to appreciate the nature of the crime, then, is the essence of the test usually favored. But such a test discredits itself by its rejection of the one reasonably sure index of insanity, namely, controllability. You can walk for miles through the wards of large mental hospitals and you will find only a small proportion of the patients who do not know the difference between right and wrong. The bulk of certified patients know full well the difference, but they fail to apply that knowledge to the everyday things of life—they lack self control.

Sir James Stephan remarked many years ago in his "History of the Criminal Law of England," about the connection between insanity and controllability and went on to say that if ever the Criminal Law of England should be codified, it should be made clear that the essence of insanity is loss of self control. From the legal standpoint, it is taken for granted that if a motive for a crime is obvious, the person accused of the crime is sane, and, being sane, responsible. But even a madman may have a motive. The fact may be ignored that an insane person, being endowed with the same instinctive passions as the one who is sane, may direct those passions towards the fulfillment of that motive. The sane man with a motive can regulate the operation of that instinct which urges him to realize his motive. The psychotic cannot exercise that control. The psychotic, like the sane man, may "know the difference between right and wrong, but he differs from the sane man by his inability to choose between right and wrong." Further, a person may be sane but irresponsible. A child under the age, for example, of seven, may be perfectly sane, but the law exempts him from criminal liability. Again, a man may, while sleeping with his wife, dream that he is being attacked by a wolf and, in his dream, grapple with the wolf

and strangle it, only to find on waking that he has strangled his wife. You may argue that a sane man asleep is still a sane man. But the mind in sleep can be anything but normal. You only have to recollect the ghastly nature of some of your dreams to realize that your mind in the dream state runs amuck, free, uncontrolled and literally abnormal.

In a criminal trial it is insanity which must be proved, not sanity, for just as it is a fundamental assumption in law that every man is innocent until he has been proven guilty, so every man is deemed sane until his insanity has been established. Insanity may be advanced when it appears that the accused is suffering from mental disorder such as to render him incapable of instructing counsel for his defense. At times it is difficult to differentiate between whether the accused feigns insanity, "mute of malice," mute, as a definite form of insanity, mute being obstinate, or mute "by the visitation of God," that is, deaf mutism.

You are all familiar with the concepts of the "criminal insane" and the "insane criminal." The difference between these two classes has never been so finely defined as it was by a writer in the *Medico-Legal Journal* of New York for September, 1898. "In a strictly legal sense," he explained, "there is no insane criminal. The act of the insane, which in the sane would be criminal, lacks every element of crime. A sane man who has committed a crime may thus become insane, either before or after conviction for the crime. He may be rightfully called an insane criminal. If the insanity developed before the trial, the law would suspend his trial while the insanity continued. If the insanity came after conviction, he should then be treated as an insane man, not as a criminal." If you delve back into the origin of our laws, you will find that as insanity was not then regarded as such, the question of criminal responsibility could not, and did not, arise. Though, curiously enough, when insanity gradually became to be recognized, the criminal acts of the insane interested the courts of those days, not so much as regards the disposal of the accused, as the disposal of his property, a verdict of guilt involving, in certain cases, forfeiture of the whole or part of his goods. Further, the only form of insanity recognized as such



was permanent insanity. Neither partial nor intermittent insanity was recognized. The recognition, as insanity, of permanent and total insanity only, persisted until the middle of the 18th Century and its operation in practice is illustrated by the case of a man, Arnold, who, under the delusion that the then Earl of Onslow (1724) was persecuting him, by sending invading armies of devils into his bedroom every night, shot at and wounded Lord Onslow. Insanity was pleaded in his defense, but dismissed as irrelevant by the Justice on the ground that Arnold could not be regarded as insane "unless he was *totally* deprived of his understanding and memory and did not know what he was doing any more than an infant, a brute or a wild beast." Later on, the attention of jurists was attracted to the question of criminal responsibility by the appearance of Blackstone's famous "commentaries" (1765) in which he pleaded for a reduction in the number of offenses punishable by death and a more humane conception of insanity. Two other circumstances also aroused interest in the question: the insanity of the reigning Monarch George III, and in 1800 a homicidal attack on that insane King by an insane subject, Hadfield, who suffered from auditory hallucinations; believed he was ordered by the Deity to sacrifice himself for the sins of the world. The jury, by directed verdict, found him "Guilty but Insane." In 1840 a youth named Oxford was tried in Old Bailey for the attempted murder of Queen Victoria, in that he fired twice at the Queen as she drove along in an open carriage. At the trial medical and other evidence disclosed abundant proof of insanity in the family, Oxford's inclination to revel in his act, his delusion that he was the leading light of an existent anarchist group, total inability to judge or reason, no moral sense, and indifference to his fate if found guilty. He was, accordingly, acquitted on the ground of insanity at the time of the act and inability to dis-

tinguish between right and wrong. In 1843 the famous case of the paranoic McNaughton, with which you are all undoubtedly familiar, provoked such debate that it became a distinct precedent. McNaughton suffered from delusions of persecution. He turned his attention to Sir Robert Peel, who he thought was his enemy. Unfortunately, he mistook a Mr. Drummond for Sir Robert Peel, waylaid and murdered him. Insanity was pleaded and, for the first time, the theory of partial insanity, advanced just at that time in France by the psychiatrist, Esquirol, was employed, resulting in acquittal on the ground of insanity. The answers of the fifteen judges who were given questions by the House of Lords established the precedence of the McNaughton Rule.

It is recognized, for example, that there are certain borderline cases whose actions are determined more or less by the same motives and consideration as those whom we call normal and upon whom the fear of punishment acts as a deterrent.

The Freudian doctrine of psychological determinism denies the existence of chance in the psychical world as in the physical world. Freud recognizes the term "responsibility" only as denoting the normal reaction of civilized society to any specified act. Neither lawyers nor psychiatrists have been able to evolve, either separately or conjointly, any rigid definition of insanity, for the simple reason there is none; and, since it is virtually impossible to define insanity, it is still less possible to define responsibility for the latter is governed by the former. The nearest approach to a workable definition of responsibility is that of Rosanoff, a Freudian, who says, "Responsibility, in the sense of profitless retribution for wrongdoing, does not exist scientifically in any case. On the other hand, everybody is responsible in the sense of being liable to forfeit his liberty, property or the restoration of damage caused by him."

## ANIMAL EXPERIMENTATION\*

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Another type of experiment was concerned with poisons. Fontana, Magendie, Brodie and Johannes Müller fed or injected poisons and observed the response of animals so treated, autopsying them after death.

Physiologists at the turn of the nineteenth century had a better background than their predecessors. Methods of chemical analysis, a knowledge of gases, an interest in electrical phenomena and a greater appreciation of the experimental method served to advance the science. Up to the first decade or two of the nineteenth century, physiological technic was in the kitchen utensil stage. Hewson spoke of teacups and tin pans as experimental materials. Leeuwenhoek, Spallanzani, Galvani and others used many familiar household articles. Quills and animal bladders were common experimental accessories, and excised arteries and bird tracheæ served as flexible tubing.

Under Magendie, Johannes Müller and their students, special equipment came into use. Pipettes, rubber tubing, special canulae and syringes were devised. Special equipment of physicists and chemists was adapted. Poiseuille devised the U-tube mercury manometer for measuring pressure in place of the long vertical tube used in the blood pressure experiments of Hales. Many innovations came from the laboratories of Claude Bernard, Ludwig and Helmholtz. By the mid-nineteenth century, the kymograph, the myograph and several types of artificial respirators were devised. Later, Marey and others developed more extensive types of graphical methods.

Physiology was distinctly entering upon its modern phase as a discipline quite apart from anatomy in having characteristic equipment and methods. As early as the 1830's, the newer attitude in physiology became evident. Haller's textbooks became obsolete, and many of the older methods went with them. Vivisection in the sense of dissection of living animals for simple observation was abandoned, and in its place

came methods of experimental analysis of animal function. The determination of physiological actions by simple autopsy following administration of poisons, alteration of respiratory gases or injection gave way to methods of studying changing patterns in the living animal. In the hands of Pasteur and early experimenters on infectious diseases, however, the older method of autopsy again became temporarily significant. Magendie had occasionally used opium to deaden pain in experimental animals, and, with the discovery of general anesthesia, this method was adapted to allay pain and to facilitate experimentation by quieting the animal.

During the nineteenth century, invertebrate animals were not routinely used as in earlier centuries. The frog, that "Job of physiology," was the most frequently used animal, and the turtle came to be next in importance among the cold-blooded animals. The dog, rabbit, cat and occasionally draft animals and birds became routine subjects. Though native animals were predominant, the guinea pig, imported from Peru and tropical America as a children's pet, came into use. For instance, William Allen, in 1809, and Brown-Sequard later used them experimentally. Magendie tended to use dogs as standard animals, these being obtained from the vagrant canine population of Paris through the medium of professional dog-catchers.

Occasionally, physiologists experienced difficulty in obtaining animals. The dog, for instance, which was subject to von Baer's demonstration of the first mammalian ovum was a household pet of his friend Burdach, who turned it over to von Baer for the demonstration.

In 1844, Claude Bernard made an experiment on a dog obtained through regular channels and inserted a silver canula in its stomach. After the animal had convalesced and was ready for a long-time experiment, the dog escaped from its enclosure. A day or so later, an irate man, the local police commissioner, who claimed to be the dog's master, appeared. When explanations were

\*Continued from January, 1938, issue.



made, it became apparent that the dog had been stolen and sold for experiment. Bernard removed the canula and returned the dog to its master, who thenceforward evinced a friendly lay interest in Bernard's experiments. These, however, were but casual incidents in the studies of research workers.

Active resistance to the progress of research arose when humane societies objected to physiological experiments. The later eighteenth and early nineteenth centuries were periods of great humanitarian activities, and the awakened interest in human values led to such substantial advances as the abolition of slavery, poor relief and prison and hospital reform.

Jeremy Bentham pointed out that humane treatment of domestic and draft animals should be a significant feature of humanitarian activities. The first official recognition of this humane idea was "Martin's Act" of 1822, a parliamentary bill which provided penalties for mistreatment of cattle, draft and domestic animals. Enthusiasts in England saw an important outlet for humanitarian ideals in the suppression of cruelty to animals, and, in 1824, under Richard Martin, formed the Royal Society for the Prevention of Cruelty to Animals. During the 1840's, the London SPCA turned its attention to antivivisection propaganda and sponsoring prize essay contests. It was also at this time that German and Austrian societies appeared with antivivisection as a prominent feature.

To members of the humane societies, the procedure of physiologists was meaningless. They were shocked at the simple vivisection technic of earlier years, and the more complicated technics and careful planning of experiments were considered nothing more than intentional brutality. The mule driver, the sportsman, the furrier and the butcher did not have such devious methods of handling animals. A group of extremists referring to themselves as antivivisectionists wrote to the public press countless letters rife with such adjectives as "atrocious," "brutal," "cruel," "horrible," "barbarous," "piteous" and other terms which showed an impassioned rather than a judicious attitude.

In 1860, a large deputation of the London SPCA met in Paris with the Société

Protectrice des Animaux. The society had unearthed an intolerable practice in a French veterinary school at Alfort. At this school, the students performed under supervision a series of practical operations on living unanesthetized animals. Standard operations on the hoofs, hocks and tail were made on old horses and were followed by more severe procedures. Here was indisputable proof of vivisection—a dissection of living animals. The London society protested to the French emperor, Louis Napoleon, who temporarily prohibited the practice and referred the matter to the Académie de Médecine for official consideration. A committee of the academy under Moquin-Tandon reported on the importance of animal experimentation and stated that the practice was invaluable in the hands of trained investigators.

An international congress of SPCA was held in 1862 with vivisection as the chief subject for discussion. In England, increased agitation against the use of animals appeared in the newspapers, and, in 1871, a resolution was passed by the physiological section of the British Association for the Advancement of Science at its Edinburgh meeting. The resolution recommended that anesthetics be used in experiments, if at all possible, that demonstrations before students or others should not include painful experiments, and that experiments should be performed only by trained investigators with adequate assistance and instruments. It further recommended that practice operations on animals for the purpose of obtaining manual dexterity among students ought not to be performed.

Under Martin's Act, domestic animals had been protected against cruelty, and although the humane organizations had been attempting for years to indict physiologists for cruelty, no formal charges had been pressed. Between 1835 and 1876, 28,209 convictions had been made under the act, but no physiologist had been involved.

In 1874, the British Medical Association invited Eugène Magnan, a French physiologist, to present a program at its Norwich meeting. Magnan demonstrated an experiment in which the effects of alcohol and absinthe were compared, a dog being injected with each drug. The SPCA instituted its first prosecution as a result of this

experiment, but it was unsuccessful since Magnan was beyond the jurisdiction of the English court. Several surgeons testified against their French guest, one asserting that his sportsman training would not permit him to allow dogs to be mistreated by experiments which proved nothing. (Magnan was later given a prize in his own country in recognition of the importance of his experiments.) In fact, the medical profession as a whole gave but mild support to proponents of animal experiment. The *Lancet* under the Wakelys bent over backwards in order to be fair and humanitarian, contenting itself with impartial comments almost up to the very month of antivivisection legislation in 1876. *L'Union Médicale* also showed great sympathy toward the antivivisectionists.

Following the Norwich incident, letters and articles appeared in increasing numbers and, in 1875, a Parliamentary Commission was appointed to investigate. After many hearings, the Royal Commission reported, indicating that charges of cruelty had been exaggerated and that the work of experimenters was of great value. The Commission, however, recommended that experimenters be licensed, that demonstration experiments be discontinued and that conditions similar to those already outlined by the British Association should be mandatory.

The Law of 1876 which resulted from the investigation, when it finally appeared after last minute action on the part of medical organizations had stripped it of extreme and insulting prohibitions, was still strict. Experimenters must be licensed annually by the Home Secretary after obtaining recommendations from the officers of high scientific, medical or veterinary organizations. Licenses allowed experiment on animals if anesthetics were used, if the animals were killed after the termination of an experiment and if the nature of the experiment were reported to the Home Office. Any experiment planned that involved pain, that was for demonstration of physiological laws to classes, that demanded the maintenance of life in the animal after operation, that avoided the use of anesthetics and any repetitions of an experiment made to test its validity must be done under special certificates. In a legal sense, the

law put great powers in the hands of the Home Secretary. He could grant or refuse licenses and consent to the prosecution of physiologists—all without any training to fit him for this responsibility.

In legislating against demonstration experimentation, the law virtually prohibited humane organizations from visiting laboratories. Societies for the total abolition of vivisection, which increased in number even after the passing of the law, thus had no direct contact with the practice which they sought to prohibit.

English physiology at the time of antivivisection legislation was in a transition state. Physiology had not received recognition as an independent science; histology and embryology were considered as physiological disciplines and the subject was ordinarily taught by anatomists. The records of the licenses for animal experimentation during the first five years of the antivivisection law show that in the whole of the British Isles less animal experimentation was practiced than in a modern, large, American medical school. Twenty-five to forty licenses were issued per year (some not being used), and three to five hundred experiments were made. These figures referred to frog and turtle experiments as well as to those on higher forms.

During the activities of the London SPCA and the antivivisection organizations, physiologists in England—Sharpey, Huxley, Rutherford, Gangee, Ferrier, Stirling, Burdon-Sanderson, Foster—were very few in number. It was a period, however, of increasing interest in the science. In 1878, the first volume of the *Journal of Physiology* appeared under the editorship of Michael Foster and with the coöperation of American physiologists. This journal is predominantly a record of physiology in England under legal restriction. Despite handicaps, it shows the activity of such men as Langley, Gaskell, Ringer, Bayliss, Starling, Sherrington and Barcroft in developing English physiology to a state not inferior to other countries.

In 1866, the American Society for the Prevention of Cruelty to Animals was founded in New York by Henry Bergh, and although this organization disclaimed any connection with antivivisection activities, other local societies arose, and in a few



years, antivivisection legislation was proposed in New York (1879), Massachusetts and Pennsylvania. The proposed legislation was never reported from committee, but time and again new efforts were made to force legislation in increasingly innocuous form. Antivivisectionists came to be typed as a minority group whose suggestions were tabled as a routine. It has usually been considered in this country that the general laws for the protection of animals against cruelty were adequate, and that special restrictive laws against experimenters were legally unnecessary. Nevertheless, antivivisection legislation is routinely proposed in a half dozen states each year. In two states, Colorado and California, such legislation has been put to public vote, but the measures were defeated in each case. Even so, it occasionally became difficult for physiologists in restricted localities to conveniently procure sufficient experimental animals. In St. Louis, for instance, and it has happened in other localities, humane societies have occasionally obtained control of impounded animals and have refused to deliver them for experimental purposes.

In England, the Protection to Animals Act and the Animals' Act were passed in 1911 and 1919 after considerable antivivisection activity. In America, simultaneous agitation appeared, but without the passing of laws. In the first decade of the twentieth century, the American Medical Association with the coöperation of American physiologists codified a series of regulations regarding the conduct of experiments in American laboratories which was as follows:

I. Vagrant dogs and cats brought to this laboratory and purchased here shall be held at least as long as at the city pound, and shall be returned to their owners if claimed and identified.

II. Animals in the laboratory shall receive every consideration for their bodily comfort; they shall be kindly treated, properly fed, and their surroundings kept in the best possible sanitary condition.

III. No operations on animals shall be made except with the sanction of the Director of the Laboratory, who holds himself responsible for the importance of the problems studied and for the propriety of the procedures used in the solution of these problems.

IV. In any operation likely to cause greater discomfort than that attending anesthetization, the animal shall first be rendered incapable of perceiving pain and shall be maintained in that condition until the operation is ended.

Exceptions to this rule will be made by the Director alone and then only when anesthesia would defeat the object of the experiment. In such cases

an anesthetic shall be used so far as possible and may be discontinued only so long as is absolutely essential for the necessary observations.

V. At the conclusion of the experiment the animal shall be killed painlessly.

Exceptions to this rule will be made only when continuance of the animal's life is necessary to determine the result of the experiment. In that case, the same aseptic precautions shall be observed during the operation; so far as possible the same care shall be taken to minimize discomforts during the convalescence as in a hospital for human beings.

In Germany, in the 1880's, a bill for the limitation of animal experimentation was presented to the Reichstag and the testimony of Virchow as to the significance of the method prevented legislation.

In the latter decades of the nineteenth century, physiology assumed its modern character. Electrical current from central power stations, instruments for measuring electrical energy, more certain knowledge provided by physicists in the fields of mechanics, heat, light and sound, and the x-ray received application by physiologists. Graphical methods and the use of photography were standard technics. The statistical method had been adapted in many cases to experiments so that criteria of reliability were available. The older method of recording protocols became of minor significance. Complex technical procedures were common in experiments. Many variables were simultaneously recorded with kymographic and photographic records. Perfusion experiments were made on isolated organs or excised parts of animals, and the complex technic of crossed circulation experiments came into occasional use. In the latter procedure, the blood supply to a region is provided by anastomoses with a second animal while the nerve supply is not altered. Pavlov showed the value of making long time observations on animals that had completely recovered from operations which altered normal physiological functions. He also showed the significance of avoiding operative shock and the desirability of maintaining a normal psychological state in experimental animals.

The method of animal experimentation likewise came to be used in fields of surgery, pharmacology, toxicology, experimental pathology, bacteriology and immunology. Application of animal experimentation in the hands of Pasteur and other bacteriologists gave emphasis to the significance of



controls, and their experiments which were best conducted on small animals gave rise to the practice of breeding colonies of small animals, such as rabbits, guinea pigs, rats and mice, for experimental purposes. The studies in the chemistry of nutrition, in vitamins and hormones, were also done, to a large extent, on small animals. The knowledge of Mendelian heredity introduced about 1900 emphasized the importance of homogeneous animals strains. Accordingly,

inbred stocks, such as the albino rat strain of the Wistar Institute developed since 1907 under H. H. Donaldson and M. J. Greenman, came to have a great importance in small animal experimentation. The complexity of physiological problems, particularly on the nervous system, and the difficulty in transmitting diseases to certain small animals gave rise in the post-war period to increasing use of the monkey and ape.

#### Serodiagnostic Tests for Syphilis as Performed by Thirty-nine State Laboratories: Comparative Study

In a report of the Committee on Evaluation of Serodiagnostic Tests for Syphilis, Thomas Parran, Washington, D. C., and his associates (*Journal A. M. A.*, Aug. 7, 1937), state that the results achieved in the first evaluation study of serodiagnostic tests for syphilis in the United States reflected great credit on several of the serologists who had developed original methods. It was pointed out in the report of the committee that the actual serologic testing was done under relatively ideal conditions in the laboratories of the originators of the methods and that the results did not necessarily compare with those attained in other laboratories utilizing the same methods. In the second evaluation study the committee attempted to meet more closely than was possible in the first evaluation project the conditions encountered in ordinary practice. The efficiency of thirty state, municipal or private laboratories in the performance of serodiagnostic tests for syphilis was measured. The results achieved in many of the state and local laboratories were quite comparable with those attained by the originator of the method employed, who tested comparable specimens as a control measure. It was also obvious that the serologic testing in certain state and local laboratories was highly inefficient. These observations led the committee to recommend that the United States Public Health Service make an annual comparison of serodiagnostic tests for syphilis done by all state laboratories. It was further recommended that the state laboratories should in turn offer a similar opportunity for comparative testing to the municipal, hospital and private laboratories within each state. It was, however, quite apparent from the results reported by some of the state laboratories that it would be unwise for them to inaugurate a method of control of the local laboratories within their boundaries until they had attained a much higher level of efficiency. In accordance with the recommendations of the committee, the Surgeon General of the United States Public Health Service invited the health officers of the forty-eight states and the District of Columbia to participate in an evaluation study. The invitation was accepted by the health officers of thirty-nine states. A study of the tables and graphs reveals that some of the state laboratories are qualified neither to perform efficient serodiagnostic service nor to inaugurate any system of state licensure or approval of local laboratories within their respective states. On the other hand, it is gratifying to observe that in many of the state

laboratories the performance of serodiagnostic tests for syphilis is maintained at a highly efficient level. A study of the technics employed in the serodiagnostic tests for syphilis submitted by the state laboratories reveals that many of them have deviated greatly from the technics described by the originators of the methods. Many of the tests that were designated as Hinton, Kahn, Kline or Kolmer tests by the performers were so modified that it would be an injustice to the originators of the methods to refer to them as such. The data derived from this investigation indicate that the routine employment of a single serodiagnostic test, although performed by competent workers, is occasionally unreliable. If a single test is used as a routine the laboratory should be prepared and willing to carry out a second test with a different method on request. The extraordinary disparity in the results of this study indicates the urgent need for the provision of intensive and extensive training of personnel in certain of the laboratories. The committee made the following recommendations to state health officers: 1. That provision be made for adequate training of state and local laboratory technicians in the laboratories of the originators of the methods employed in the respective laboratories, and that in the future only thoroughly competent technical personnel be employed. Funds now being made available to the states under the provision of the Social Security Act and allotted for the training of personnel should be utilized for the tuition and stipend of the state and local laboratory technicians. 2. That a system of periodic inspection of state laboratories by thoroughly trained serologists of the United States Public Health Service be inaugurated and made available on the request of state health officers, and that advantage be taken of the system of comparative examination of serodiagnostic tests for syphilis to be extended annually by the United States Public Health Service. 3. That the facilities available for special study of serologic methods in the Venereal Disease Research Laboratory of the United States Public Health Service at Stapleton, Staten Island, N. Y., be further utilized for the training of personnel from state laboratories. 4. That the need is again emphasized for the development by state laboratories of a system of periodic comparative examination of the performance of serodiagnostic tests by municipal, hospital and private laboratories located within the respective states. 5. That full advantage be taken of existing local laboratory facilities and that provisions be made to approve and subsidize qualified local laboratories for the performance of diagnostic services in the control of syphilis.



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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FEBRUARY, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### WHAT IS THE AMERICAN MEDICAL ASSOCIATION?

EVERY member is or should be conversant with the functioning and services rendered by his county medical society. The establishment of the headquarters of the state medical society at Lansing with a full time executive is rendering a service that is realized by most members of the Michigan State Medical Society. To recapitulate: the medical defense feature; acting as a liaison between the legislature and the medical profession as a whole in all matters pertaining to public and private health; the functioning of various standing committees; preparations for the annual meetings; and, in general, the conduct of business in the broadest sense which pertains to the medical profession of this state as a whole, and might we add, last but not least, the publi-

cation of THE JOURNAL of the Michigan State Medical Society.

But what is the American Medical Association? Each member who has paid his annual membership or fellowship dues to the American Medical Association has received a small brochure of sixteen pages which answers this question in concise form. It is hoped that whoever receives this brochure will take a half hour off to read it through. But for fear that it may have fallen into the hands of some doctor whose time is at a premium, we shall attempt a summary.

The House of Delegates of the American Medical Association elected from each state determines the policy of the Association. The administration of that policy is the function of the Board of Trustees which acts in the interval of the annual meetings held from year to year in various sections in the United States. Immediately under the House of Delegates is the Judicial Council which has jurisdiction on all questions of ethics as well as the interpretation of laws of the organization. Among these are obligations, rights and privileges of fellowship as well as controversies arising under the constitution and by-laws to which the association is a party. The Judicial Council is composed of five members elected for five years.

Then there is the Council on Medical Education and Hospitals. The influence of this council during recent decades has been felt in the advancement of requirements for college entrance, lengthening of college sessions, reorganization of courses as well as improvement in building and laboratory facilities. The council on medical education and hospitals is equipped to supply to members of the associations any information on the subject of either hospitals or of medical education.

The Council on Scientific Assemblies arranges programs of general meetings and of scientific assemblies and secures co-operation between the sections. This committee passes on questions of policy in relation to the scientific work and investigations and reports on scientific questions.

For over thirty years, the biographical department has collected personal data regarding medical graduates and licensed phy-

sicians of the United States and Canada. These records are available to all fellows of the Association. Part of their work is the American Medical Directory which is issued every two years.

The Council on Pharmacy and Chemistry offers protection to physicians in choosing proprietary remedies. This body constitutes a scientific judicial investigating medium for newly introduced medicinal preparations. The results of its work are reported in *THE JOURNAL* and annually in the book, "New and Non-Official Remedies." The Council on Physical Therapy performs a like function in regard to the non-medicinal therapeutic agents.

The Council on Foods endeavors to establish truthful advertising of foods in the interest of the public. The seal of approval of the American Medical Association is placed on "accepted foods." The value of this approval is evident in the numerous requests, not only from physicians, but from food industries and advertising agencies, on matters pertaining to food and food advertising.

The American Medical Association chemical laboratory is admirably equipped for investigation, not only of newer remedies but for special types of analyses. It functions along with the Council on Pharmacy and Chemistry.

The Bureau of Investigation is concerned with patent and proprietary medicines as well as all forms of quackery, medical fads and fakes. It supplies information to physicians who may want to address local organizations on some phases of the patent medicine evil. The Bureau of Health and Public Instruction works through the physician in medical societies. It has direct contact with the public through the lay health magazine, *Hygiea*. Service to the public consists also in correspondence in which approximately 15,000 questions a year put by lay inquirers are answered. The radio network program is also a function of this committee. The Bureau of Exhibits has in charge the science and health exhibits of the association.

An important service rendered is that of the Bureau of Medical Economics which studies all phases of general economy which have a bearing on the practice of medicine. The Bureau collects, tabulates and studies,

and prepares for publication and distribution data pertaining to economics of practice. Many of our readers are already familiar with this brochure and booklets on different subjects as well as the work of the Bureau published from time to time in the *Journal of the American Medical Association*.

Then there is the American Medical Association Reference Library where more than 1,300 medical journals, domestic and foreign, are abstracted and indexed. The abstract feature of the journal is familiar to all readers. An index of articles currently published is provided through the *Quarterly Cumulative Index Medicus*.

The American Medical Association publish not only the *Journal of the American Medical Association* and *Hygiea*, but a number of special journals such as *Archives of Internal Medicine*, *American Journal of Diseases in Children*, *Archives of Neurology and Psychiatry*, *Archives of Dermatology and Syphilology*, *Archives of Surgery*, *Archives of Otolaryngology*, *Archives of Pathology*, *Archives of Ophthalmology*, and the *Quarterly Cumulative Index Medicus*.

In addition to it all, through the secretary of the American Medical Association and its councils and bureaus, the association is always willing to lend any assistance asked to various state and county medical societies. Probably no other organization of a scientific nature is in closer touch with its individual members or in a position to render greater service when called upon. Do not, however, be content with this editorial summary of the activities of the national organization, but read carefully the little silver and blue covered brochure which accompanies your membership card.

## ANALGESIA IN LABOR HAS ITS DANGERS

IN THIS number of *THE JOURNAL* is a paper by Drs. Schreiber and Gates on the subject of "Cerebral Injury in the New-born Due to Anoxia at Birth." It is not too far afield to say that only the worst results come under the care of the neurosurgeon. May we not then assume that conditions here described are extreme results



of the efforts towards painless delivery. The fact, however, that such is possible must give us pause. Painless childbirth has always been a consummation devoutly to be wished. No doubt the refinements of civilization have placed the modern woman at a disadvantage as compared with her primitive ancestor. For centuries, pain was considered an accompaniment of childbirth which had to be accepted. It was referred to in the Bible as a necessity and when Simpson of Edinburgh discovered chloroform and suggested as one of its uses the mitigation of pains of labor, the church was most formidable in its opposition. Chloroform anesthesia was denounced as unscriptural. However, humanitarianism won the victory over the Kirk so that long since with countless thousands of women, the second stage of labor has been rendered comparatively painless.

Within the past two or three decades, efforts have been made to render the earlier stages of labor painless also. Twilight sleep has received a great deal of advertising in the lay press so that the idea has had almost a universal appeal among mothers-to-be. The bridge table, magazines and other means of communication such as Woman's Clubs, have spread the gospel of painless childbirth so that it has been virtually forced upon the medical profession, in many instances against their better judgment. We put it this way inasmuch as analgesia drugs are not by any means free from danger and many are more or less imperfectly understood. One should be very much guarded in using them and above all, even when properly used, one should be in a position to meet any possible emergency. The majority of confinements are now and will be for some time to come, served by the general practitioner. Many physicians with care and experience have attained a high degree of skill in obstetrics. However, a high degree of proficiency is becoming more necessary than in the pre-analgesic period. The effects of analgesia diminish the consciousness of the patient in labor to such a degree that she is unable to assist in the so-called second stage of labor, a fact that calls for instrumental delivery which in turn, as mentioned, calls for more than ordinary skill.

A wholesome regard for these new synthetic drugs and a thorough knowledge of

their action as well as contraindication will save the obstetrician much embarrassment, be he general practitioner or specialist. With the paper by Schreiber and Gates we suggest a re-reading of the "Newer Obstetrics," by Kamperman, which appeared in the December, 1937, number of this JOURNAL.

#### HE PRACTICED FIFTY YEARS

Quite frequently during the year some venerable member of the medical profession of this state is honored by a complimentary dinner on the completion of a half century in the practice of medicine. The following little poem is very appropriate for such occasions. The author is anonymous to us. We, however, credit the *New York State Medical Journal* in which it was first printed. The occasion on which it was first read was at a half century celebration at Dorset, Vermont, during the past year. It applies to any physician who has labored in the cause of humanity wherever he may be.

Better fifty years of doing  
Than a century of thought!  
For how rare by cloistered thinking  
Has a useful thing been wrought!

A sword kept keen and polished  
Is an enemy to dust  
But a blade unused, neglected,  
Falls a prey to mordant rust.

Half a century of endeavor!  
Half a century of toil!  
Not a thousand years can tarnish  
Not a million years can spoil.

So keep the fires a-burning  
And may you never feel  
The hammer growing heavier  
As you forge your hoops of steel.

After all these years of service  
What we say seems oh! so slight—  
For we feel and know all honor  
Is yours by hard-earned right.

Also yours—Beloved physician,  
Sage, counselor and friend—  
Is our heart's true deep devotion  
Now and ever without end.

Affable Waiter—How did you find the steak sir?  
Diner—Oh, quite accidentally. I moved that piece of potato, and there it was, underneath.

War in Church—A bishop was invited to dinner. During the meal he was astonished to hear the young daughter of the house state that a person must be very brave these days to go to church.

"Why do you say that?" asked the bishop.

"Because," said the child, "I heard papa tell mamma that last Sunday there was a big shot in the pulpit, the canon was in the vestry, the choir murdered the anthem, and the organist drowned the choir."—*Exchange*.

Some of the depression sufferers are like the darkey who had been playing poker.

He said: "Tell you, boys, I dun los' a heap o' money las' night."

"How much did you lose?"

"A hundred and eighty-seben dollars an' fohteen cents."

"Golly! dat wuz a heap o' money."

"Yas, siree, and de wust of it wuz, de fohteen cents wuz cash."—*Exchange*.

# President's Page

## TEAMWORK

ONE picture is worth ten thousand words so a small cartoon, with the above caption, is reprinted in this issue of THE JOURNAL.

Teamwork, it shows, leads to success!

Teamwork is a requisite of every medical society in this enigmatical year of 1938 when intelligent courage and strength of numbers is required to fight fear and subversive forces.

Teamwork is necessary between the component county medical society and the State medical society.

Teamwork is likewise vital between the allied scientific professions of medicine, dentistry, nursing, pharmacy, etc.

Encouraging is the recent formation of the Michigan Health League, composed of the allied professions of Michigan, augmented by laymen interested in health. This agency is designed to serve the health and best interests of the people of this state by informing the public concerning the proper evaluation of the allied sciences, and by safeguarding the people against impositions and misrepresentations of unscrupulous charlatans. The League will provide a medium for discussing and taking concerted action on all matters of common interest to licensed physicians, dentists, nurses, pharmacists, etc.; it will work to elevate ethical professional standards; it will seek enactment of laws to effect the greater usefulness of the allied scientific sciences; it will support public health departments, approved hospitals, ethical pharmacists, laboratories, and other qualified agencies in their efforts to reduce the prevalence of disease and disability.

Teamwork among the scientific professions of Michigan is here. The Michigan Health League is *your* vehicle. You and your health-minded lay friends are invited to get on the band-wagon and join the parade of progress—to Success.

Respectfully submitted,



President, Michigan State Medical Society.



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## ANNUAL CONFERENCE OF COUNTY SECRETARIES

THE Annual Secretaries' Conference for 1938 was held in Lansing at the Olds Hotel on Sunday, January 23, 10 a. m. to 4 p. m. This annual meeting, designed to inspire and instruct the county secretaries, is arranged by the State Society's Council.

The program at the 1938 conference was as follows:

Call to Order by Chairman L. E. Holly, M.D., Muskegon.

Welcome by M.S.M.S. President Henry Cook, M.D., Flint; and by Ingham County President Dana M. Snell, M.D., Lansing.

Presentation of President-Elect Henry A. Luce, M.D., Detroit; and of Council Chairman P. R. Urmston, M.D., Bay City.

### Morning Program

1. "Public Relations by the County Medical Society"—LAWRENCE C. SALTER, Medical Editor, *Detroit Free Press*.  
Discussants: A. J. Baker, M.D., Grand Rapids; C. G. Clippert, M.D., Grayling.
2. "How to Achieve Maximum Membership"—MARTIN H. HOFFMAN, M.D., Eloise.  
Discussants: Wm. M. Brace, M.D., Ann Arbor; John A. Hookey, M.D., Detroit.

### Recess for Noonday Chicken Dinner

3. "The S.S.S. of Medical Practice"—ALLAN W. McDONALD, M.D., Detroit.
4. "Medicine in the Front Line Trenches"—CHARLES B. WRIGHT, M.D., Minneapolis, Trustee of the American Medical Ass'n.

Election of Chairman for 1938.

### Afternoon Program

5. "Problems of Administering the Afflicted Child Law"—HON. GEORGE T. GUNDRY, Auditor General of Michigan.
6. "What's Going On In Michigan"—L. FERNALD FOSTER, M.D., Bay City, Secretary of the M.S.M.S.  
Discussants: John J. McCann, M.D., Ionia; A. F. Bliesmer, M.D., St. Joseph.
7. Round Table Discussion on Preventive Medicine. Chairman: DON W. GUDAKUNST, M.D., State Health Commissioner.  
Cancer: O. A. Brines, M.D., Detroit.  
Immunization: Edgar Martmer, M.D., Detroit.  
Maternal Health: A. M. Campbell, M.D., Grand Rapids.  
Mental Hygiene: H. A. Luce, M.D., Detroit.  
Preventive Medicine: L. O. Geib, M.D., Detroit.  
Syphilis: R. S. Breakey, M.D., Lansing.  
Tuberculosis: B. H. Douglas, M.D., Northville.

The Editors' Conference, comprising the editors of medical bulletins in Michigan, was held on the same day as the County

Secretaries' Conference, in Lansing, January 23, 1938. A round-table discussion relative to problems of editing and managing a Bulletin, what material is best suited for publication, and suggestions for improvements and refinements were thoroughly discussed.

County medical societies having bulletins, together with the names of their editors, include:

Calhoun—Wilfrid Haughey, M.D., Battle Creek.  
Cass-Berrien—A. F. Bliesmer, M.D., St. Joseph.  
Bay—W. G. Gamble, M.D., Bay City.  
Genesee—T. S. Conover, M.D., Flint.  
Ingham—H. C. Rockwell, M.D., Lansing.  
Jackson—H. W. Porter, M.D., Jackson.  
Kalamazoo—L. W. Gerstner, M.D., Kalamazoo.  
Kent—John M. Whalen, M.D., Grand Rapids.  
Muskegon—R. H. Holmes, M.D., Muskegon.  
Oakland—R. G. Tuck, M.D., Pontiac.  
Wayne—(*Detroit Medical News*—weekly)—D. I. Sugar, M.D., Detroit.  
Washtenaw—Wm. M. Brace, M.D., Ann Arbor.

The following is the attendance roll of the Secretaries' Conference, Olds Hotel, Lansing, Sunday, January 23, 1938:

*Secretaries of County Societies.*—Allegan: Dr. M. B. Beckett, Allegan; Alpena: Dr. H. Kessler, Alpena; Bay: Dr. A. L. Ziliak, Bay City; Berrien: Dr. A. F. Bliesmer, St. Joseph; Branch: Dr. F. S. Leeder, Coldwater; Calhoun: Dr. Wilfrid Haughey, Battle Creek; Clinton: Dr. T. Y. Ho, St. Johns; Eaton: Dr. T. Wilensky, Eaton Rapids; Hillsdale: Dr. E. G. McGavran, Hillsdale; Ingham: Dr. R. J. Himmelberger, Lansing; Ionia-Montcalm: Dr. John J. McCann, Ionia; Jackson: Dr. Horace Wray Porter, Jackson; Kalamazoo: Dr. Louis W. Gerstner, Kalamazoo; Lenawee: Dr. Esli T. Morden, Adrian; Livingston: Dr. D. C. Stephens, Howell; Luce: Dr. C. D. Hart, Newberry; Macomb: Dr. R. F. Salot, Mt. Clemens; Manistee: Dr. C. L. Grant, Manistee; Muskegon: Dr. Leland E. Holly, Muskegon; Newaygo: Dr. W. H. Barnum, Fremont; Oakland: Dr. O. O. Beck, Birmingham; Oceana: Dr. N. W. Heysett, Hart; O.M.C.O.R.O.: Dr. C. G. Clippert, Grayling; St. Clair: Dr. Jacob H. Burley, Port Huron; St. Joseph: Dr. J. W. Rice, Sturgis; Tuscola: Dr. Robert R. Howlett, Caro; Washtenaw: Dr. Wm. M. Brace, Ann Arbor; Wayne: Dr. John A. Hookey, Detroit; Wexford: Dr. Benton A. Holm, Cadillac.

*Presidents of County Societies.*—Barry: Dr. Gordon F. Fisher, Hastings; Bay: Dr. C. L. Hess, Bay City; Ingham: Dr. Dana M. Snell, Lansing; Ionia-Montcalm: Dr. R. R. Whitten, Ionia; Jackson: Dr. John D. VanSchoick, Hanover; Kent: Dr. Abel J. Baker, Grand Rapids; St. Clair: Dr. Charles A. Macpherson, St. Clair; Wayne: Dr. C. E. Umphrey, Detroit.

*Officers and Councilors.*—Dr. Henry Cook, Flint, President; Dr. Henry A. Luce, Detroit, President-Elect; Dr. L. Fernald Foster, Bay City, Secretary; Dr. P. R. Urmston, Bay City, Chairman of The Council; Dr. J. E. McIntyre,

Lansing; Dr. F. T. Andrews, Kalamazoo; Dr. T. F. Heavenrich, Port-Huron; Dr. George A. Sherman, Pontiac; Wm. J. Burns, Lansing, Executive Secretary.

*Guests.*—Senator Earl W. Munshaw, Grand Rapids; Representative Elizabeth L. Belen, Lansing; Representative Vernon J. Brown, Mason; Dr. R. E. Pleune, Lansing; Dr. W. G. Gamble, Bay City; Dr. Roy C. Perkins, Bay City; Dr. M. R. Slattery, Bay City; Dr. L. O. Keagle, Battle Creek; Dr. Stanley T. Lowe, Battle Creek; Dr. R. C. Winslow, Battle Creek; Dr. T. S. Conover, Flint; Dr. F. B. Miner, Flint; Dr. Donald Fleming, Hillsdale; Dr. L. G. Christian, Lansing; Dr. A. W. Newitt, Lansing; Dr. H. C. Rockwell, Lansing; Dr. John F. Sander, Lansing; Dr. Lillian R. Smith, Lansing; Dr. Robert J. Armstrong, Kalamazoo; Dr. J. D. Brook, Grandville; Dr. J. D. Miller, Grand Rapids; Dr. E. W. Caster, Mt. Clemens; Dr. J. D. Bruce, Ann Arbor; Dr. B. W. Carey, Detroit; Dr. Richard M. Johnson, Detroit; Dr. Paul A. Klebba, Detroit; Dr. Gregory Moore, Cadillac; James A. Bechtel, Detroit; Theodore J. Werle, Lansing; Frank C. Bateman, Pontiac; Harry R. Lipson, Detroit.

Those in attendance at the County Bulletin Editors' Conference, Olds Hotel, Lansing, Sunday, January 23, 1938:

*County Bulletin Editors.*—Bay: Dr. W. G. Gamble, Bay City; Calhoun: Dr. Wilfrid Haughey, Battle Creek; Cass-Berrien: Dr. A. F. Bliesmer, St. Joseph; Genesee: Dr. T. S. Conover, Flint; Ingham: Dr. H. C. Rockwell, Lansing; Jackson: Dr. Horace Wray Porter, Jackson; Kalamazoo: Dr. L. W. Gerstner, Kalamazoo.

*Guests.*—Dr. P. R. Urmston, Bay City, Chairman of The Council; Dr. L. Fernald Foster, Bay City, Secretary; Dr. C. L. Hess, Bay City; Dr. A. L. Ziliak, Bay City; Dr. Robert S. Breakey, Lansing; Dr. Leland E. Holly, Muskegon; Dr. Wm. M. Brace, Ann Arbor; James A. Bechtel, Detroit; Harry R. Lipson, Detroit; Wm. J. Burns, Lansing, Executive Secretary.

## SECOND ANNUAL GOLF TOURNAMENT

THE day was chilly and the sun flashed intermittently, but sixty physicians enjoyed the Second Annual Golf Tournament of the Michigan State Medical Society at Cascade Hills Country Club, Grand Rapids, on Sunday, September 26, on the occasion of the M.S.M.S. Annual Meeting. The eighteen-hole course was in perfect condition, and the swimming pool looked inviting—when the sun was out; but most of the players satisfied themselves with a shower in the warm recesses of the club-house. The Local Committee, composed of Drs. M. S. Ballard, Leon DeVel, Wm. R. Torgerson, A. V. Wenger and P. W. Bloxsom, worked up the details of the convention so that everything ran smoothly.

During the dinner, prizes were presented by Dr. M. S. Ballard, chairman of the Arrangements Committee, who also announced the individual scores:

## GOLF SCORES—1937

### Championship Flight

Scratch to 10, inclusive

	G	H	Net
Harvey Hansen, Battle Creek.....	96	10	86
R. H. Baribeau, Battle Creek.....	91	10	81
John M. Murphy, Detroit.....	78	5	73
W. G. Reid, Detroit.....	82	8	74
K. S. McIntyre, Hastings.....	90	4	86
J. H. Albers, E. Lansing.....	77	5	72
R. E. Balch, Kalamazoo.....	88	7	81
R. J. Hubbell, Kalamazoo.....	89	10	79
T. E. Hoffman, Vassar.....	80	5	75
F. C. Bandy, Sault St. Marie.....	84	8	76
M. J. Holdsworth, Grand Rapids.....	77	4	73
A. A. Humphrey, Battle Creek.....	84	10	74

### First Flight

11 to 15, inclusive

E. J. Rennell, Traverse City.....	95	15	80
Alfred Dean, Grand Rapids.....	93	14	79
R. B. Harkness, Hastings.....	88	13	75
R. C. Jamieson, Detroit.....	88	15	73
R. G. Fimmie, Hastings.....	100	16	84
K. H. Johnson, Lansing.....	97	15	82
M. S. Ballard, Grand Rapids.....	98	15	83
M. A. Hoffs, Lake Odessa.....	98	15	83
W. Z. Rundles, Flint.....	83	12	71

### Second Flight

16 to 20, inclusive

R. D. Scott, Flint.....	96	18	78
G. D. Houghton, Caledonia.....	101	18	83
C. L. Hirwas, Marquette.....	83	16	67
A. E. Catherwood, Detroit.....	93	18	75
Wm. R. Clinton, Detroit.....	93	17	76
P. W. Bloxsom, Grand Rapids.....	96	19	77
T. R. Kemmer, Grand Rapids.....	96	18	78

### Third Flight

21 to 27, inclusive

E. F. Sladek, Traverse City.....	104	25	79
J. A. Hookey, Detroit.....	108	27	81
Harold D. Crane, Grand Rapids.....	94	21	73
A. R. Dickson, Battle Creek.....	104	24	80
O. A. Brines, Detroit.....	97	21	76
R. F. Webb, Grand Rapids.....	95	23	72
T. C. Irwin, Grand Rapids.....	95	23	72
H. A. Luce, Detroit.....	101	27	74
L. W. Shaffer, Detroit.....	94	21	73
Ward S. Ferguson, Grand Rapids.....	106	27	79
Geo. H. Southwick, Grand Rapids.....	100	25	75
P. L. Thompson, Grand Rapids.....	104	23	81
H. F. Dibble, Detroit.....	90	22	68
A. J. Baker, Grand Rapids.....	107	22	85
Philip A. Riley, Jackson.....	99	27	72
R. H. Denham, Grand Rapids.....	98	27	71
M. E. Danforth, Detroit.....	102	27	75
C. F. Snapp, Grand Rapids.....	101	25	76
R. E. Spinks, Newberry.....	98	22	76

### Fourth Flight

28 to 30, inclusive

Leon M. Bogart, Flint.....	111	30	81
John Wenger, Coopersville.....	116	30	86
S. C. Mason, Menominee.....	110	28	82
C. K. Valade, Detroit.....	147	30	117
Martin H. Hoffmann, Detroit.....	108	30	78
W. D. Barrett, Detroit.....	109	30	79
C. D. Benson, Detroit.....	104	30	74
G. C. Penberthy, Detroit.....	117	30	87
W. E. Barstow, St. Louis.....	120	30	90
S. W. Insley, Detroit.....	104	30	74
C. V. Crane, Grand Rapids.....	97	30	67
Wm. J. Butler, Grand Rapids.....	100	30	70
J. J. O'Meara, Jackson.....	92	30	62



SOCIETY ACTIVITY

CHAMPIONSHIP OF THE FIELD

PRIZES

DONORS

WINNERS

Low Gross President's Trophy .....	Dr. H. E. Perry, Newberry.....	} M. J. Holdsworth, Grand Rapids (77)
and One year's possession of Penberthy Trophy .....	Dr. G. C. Penberthy, 1515 David Whit- ney Bldg., Detroit..... (Past-President, M.S.M.S.)	
Low Net Packard Electro Shaver.....	Kent Co. Medical Society (President, A. B. Smith, Metz Bldg., Grand Rapids) .....	J. J. O'Meara, Jackson (62)

FIVE FLIGHTS

Championship Flight  
(Scratch to 10, incl.)

Low Gross Golf Bag .....	Dr. J. D. Brook, Grandville.....	J. H. Albers, Lansing Delegate to the A.M.A.
Low Net Globe of World .....	Dr. L. Fernald Foster, 328 Shearer Bldg., Bay City .....	John M. Murphy, Detroit (Secretary, M.S.M.S.)

First Flight  
(11 to 15, incl.)

Low Gross Medical Bag .....	Dr. J. H. Dempster, 5761 Stanton, Detroit .....	W. Z. Rundles, Flint (Editor, JOURNAL, M.S.M.S.)
Low Net Set Poker Chips.....	Dr. T. F. Heavenrich, Port Huron.....	R. C. Jamieson, Detroit (Vice Chairman, The Council)

Second Flight  
(16 to 20, incl.)

Low Gross Cocktail Set .....	Dr. A. B. Smith, Metz. Bldg., Grand Rapids .....	C. L. Hirwas, Marquette (President, Kent Co. Med. Soc.)
Low Net Travel Kit .....	Dr. P. A. Riley, 500 S. Jackson St., Jackson .....	A. E. Catherwood, Detroit (Vice-Speaker, House of Dele.)

Third Flight  
(21 to 27, incl.)

Low Gross Dispensing Set .....	Dr. Frank E. Reeder, 808 Genesee Bank Bldg., Flint .....	H. F. Dibble, Detroit (Speaker, House of Delegates)
Low Net Travel Kit .....	Bill Mennen .....	R. H. Denham, Grand Rapids The Mennen Company, Newark, N. J.

Fourth Flight  
(28 to 30)

Low Gross Pen Desk Set.....	Dr. Henry Cook, 400 Sherman Bldg., Flint .....	C. V. Crane, Grand Rapids (President-Elect, M.S.M.S.)
Low Net Travel Kit .....	Bill Mennen .....	W. J. Butler, Grand Rapids The Mennen Co., Newark, N. J.

MATURITY EVENT

Limited to players 50 years and over

Low Gross Dempster Trophy .....	Mr. J. R. Bruce, Bruce Pub. Co., 2642 University Ave., St. Paul, Minn.....	R. E. Balch, Kalamazoo (Publisher, THE JOURNAL)
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KICKERS HANDICAP

First Prize Electric Clock .....	Dr. P. R. Urmston, Davidson Bldg., Bay City .....	A. R. Dickson, Battle Creek (Chairman, The Council)
Second Prize Copper Ice Bucket with Tongs.....	Bill Burns, 2020 Olds Tower, Lansing....	J. A. Hookey, Detroit (Executive Secretary, M.S.M.S.)

## REPORT OF AUDITORS FOR 1937

WE HAVE made an examination of the balance sheet of MICHIGAN STATE MEDICAL SOCIETY as at December 24, 1937, and of the statements of income and expense and net worth for the year ended at that date. In connection therewith, we examined or tested accounting records of the Society and other supporting evidence and obtained information and explanations from the Executive Secretary and other employees; we also made a general review of the accounting methods and of the operating and income accounts for the year, but we did not make a detailed audit of the transactions.

In addition to our examination of the balance sheet and of the statements of income and expense and net worth, we made certain test checks of the records of the cash transactions and other data supporting the operating and income accounts.

The Society was organized as a corporation not for pecuniary profit on September 17, 1910 under the laws of the State of Michigan. It is affiliated with the American Medical Association and charters county medical societies within the State of Michigan. The purpose of the Society is the federation and protection of the medical profession and the extension of medical knowledge. In the furtherance of these purposes, the Society publishes THE JOURNAL of the Michigan State Medical Society.

### Balance Sheet

The balance sheet as at December 24, 1937, included herein, has been prepared on the basis outlined in this report. A summary of the assets and liabilities at December 24, 1937, follows:

Assets	
Cash .....	\$ 1,473.45
Notes and accounts receivable.....	920.48
Inventory .....	834.00
Securities—at cost less reserve.....	28,978.00
Deferred charges .....	76.46
	<u>\$32,282.39</u>
Liabilities	
Note payable .....	\$ 3,500.00
Accounts payable .....	2,855.53
Liability for funds administered.....	39.37
Unearned income .....	2,074.50
Reserve for Medico-Legal Defense Fund.....	12,048.60
Net worth .....	<u>11,764.39</u>
	<u>\$32,282.39</u>

Notes receivable for dues represent the uncollected portions of notes taken in settlement of 1931, 1932 and 1933 dues. Collections on these notes during the year ended December 24, 1937 amounted to \$7.50.

Accounts receivable for advertising, reprints and cuts were analyzed as to date of charge, as follows:

Date of Charge	Dec. 24, 1937	
	Amount	Per cent
October, November and December.....	\$ 981.51	70.59%
July, August and September.....	100.45	7.23
January to June, inclusive.....	10.25	.74
Prior to January 1st.....	298.08	21.44
TOTAL .....	<u>\$1,390.29</u>	<u>100.00%</u>

The balances due from county societies represent dues collected for the Society by two county societies and impounded in depository banks. As funds are released by the banks the Society's share will be forwarded by the county societies. During the year a payment of \$16.61 was received on one of these accounts.

Based upon our analysis of the notes and accounts and conference with the Executive Secretary as to their collectibility, it is our opinion that the

reserve of \$625.00 is sufficient to care for losses anticipated at the date of this report.

The inventory represents 278 sets of the "Medical History of Michigan," a two-volume work published by the Society several years ago. During the year 1936 the inventory value was reduced to \$3.00 a set, at which value the histories are included in the inventory at December 24, 1937.

A schedule of securities owned is included in a later section of this report, which sets forth the par value, cost and quoted market values at December 24, 1937. (*Part of the M.S.M.S. treasurer's report to be published in the March Journal.*) Unlisted securities have been valued from information furnished by brokers as to the current bid and sale prices. During the year \$4,000.00 of principal amount of bonds of the American Telephone & Telegraph Company owned by the Society were called at a premium and other bonds in the principal amount of \$18,000.00 were sold at a loss. Practically all of the proceeds from the redemption and sale of bonds were reinvested in other securities. The net loss on the sale of securities in the General Fund and Medico-Legal Defense Fund during the year in the amount of \$5,949.76 was partially offset by a reduction of \$3,492.00 in the reserve to reduce securities to quoted market values at December 24, 1937. The net effect of these transactions in the two funds is summarized as follows:

	Total	General Fund	Medico-Legal Defense Fund
Loss on sale of securities.....	\$5,949.76	\$3,817.33	\$2,132.43
Change in reserve.....	<u>3,492.00</u>	<u>3,578.50</u>	<u>86.50</u>
Net Loss on Securities Transactions .....	<u>\$2,457.76</u>	<u>\$ 238.83</u>	<u>\$2,218.93</u>

Matured coupons on bonds not in default have been included at par value, but no other accrued interest is included in the balance sheet.

Deferred charges, as shown in the balance sheet, represent costs incurred prior to December 24, 1937 in connection with advertising for the 1938 annual meeting. In our opinion, such items are properly chargeable to future operations.

As far as we could ascertain, provision has been made for all ascertained liabilities at December 24, 1937.

The note payable to the Lansing National Bank is dated December 24, 1937, is due January 25, 1938 and is secured by \$6,000.00 principal amount of bonds of the General Fund pledged as collateral.

We have included herein a statement in summarized form of the receipts and disbursements of the fund of the Joint Committee on Public Health Education, which fund has been administered by the Society in the past. In accordance with action of the Executive Committee of the Council of the Society, the balance remaining in this fund was turned over to the Joint Committee during the month of December, 1937.

Collections of 1938 dues and overpayments of 1937 dues, which were not returned to county societies, have been shown as unearned income and, in our opinion, represent income applicable to the ensuing year, except that portion which will be credited to the Medico-Legal Defense Fund when it is determined what portion of 1938 dues shall be allocated to that fund.

A separate schedule included herein shows in summary the changes in the Medico-Legal Defense Fund. Excluding sales and purchases of securities, disbursements of this fund exceeded receipts in the amount of \$1,717.31. Losses on sale and reduction in value of securities decreased this fund



## SOCIETY ACTIVITY

an additional amount of \$2,218.93. At December 24, 1937 the quoted market value of securities allocated to the Medico-Legal Defense Fund was somewhat in excess of the reserve.

Surety bonds on officials and an employee of the Society at December 24, 1937 were as follows: Medical Secretary, \$15,000.00; Treasurer, \$35,000.00; Executive Secretary, \$5,000.00; Bookkeeper, \$5,000.00.

### Income and Expense Statement

A statement of income and expense for the fiscal year ended December 24, 1937 is included herein, prepared in comparison with the income and expense statement for the prior year. A comparative statement of expenses for the two years is also included.

The increase in income resulting from a slightly larger membership was more than offset by increased expenses resulting from enlarged activities of the Society.

Net income from publishing THE JOURNAL, which is not charged with any part of the expenses of the executive office, was approximately the same as during the preceding year.

### Scope of Examination

The scope and nature of our examination and the extent of our tests of detail transactions are outlined in the following comments:

The demand deposit was verified by reconciliation of the amount reported by the depository bank to the amount shown herein. Cash on hand was counted on the morning of December 27, 1937. Recorded cash receipts for six months of the year under review were traced to the deposits shown by the bank statements on file. The recorded cash disbursements for three months of the year were compared with canceled bank checks, invoices and other memoranda. To the extent of the tests made no irregularities were disclosed.

Notes receivable were inspected by us. Ac-

counts receivable were in agreement with trial balances of the individual accounts. We did not correspond with any of the debtors to confirm the correctness of the book entries.

Securities were inspected on December 24, 1937 and market quotations were obtained to ascertain their approximate market value at that date. Purchases and sales of securities were supported with broker's memoranda.

The note payable to the Lansing National Bank was verified by correspondence with the bank. We did not correspond with the other creditors to verify the liabilities of the Society, but we reviewed the transactions entering into the accounts of the Joint Committee on Public Health Education and of the Medico-Legal Defense Fund.

In addition to the tests heretofore outlined, we tested the amount of dues collected by comparison with the membership records and by examination of unused membership certificates. Interest received was verified by inspection of coupons and by verification from the bank concerning bonds held by that institution as collateral security for notes payable. Tests were made of advertising income by comparison of billings for advertising with space used in three issues of THE JOURNAL. We also reviewed the items charged to the major expense accounts of the year.

### Opinion

In our opinion, based upon our examination, the accompanying balance sheet and related statements of income and expense and net worth fairly present the financial position of the Society at December 24, 1937 and the results of its operations for the year ended at that date. Further, it is our opinion that the statements have been prepared in accordance with accepted principles of accounting and on a basis consistent with the preceding year. January 4, 1938.

ERNST AND ERNST  
Certified Public Accountants

### BALANCE SHEET December 24, 1937

Assets		
Cash		
Demand deposit .....	\$ 1,465.83	
Office cash fund .....	7.62	\$ 1,473.45
Notes and Accounts Receivable		
Notes receivable for dues—past due .....	\$ 80.00	
Accounts receivable:		
For advertising, reprints and cuts .....	\$ 1,390.29	
From county societies for dues .....	75.19	1,465.48
	\$ 1,545.48	
Less reserve for doubtful .....	625.00	920.48
Inventory		
"Medical History of Michigan" .....		834.00
Securities		
Stocks and bonds—at cost—Note A .....	\$39,261.25	
Less reserve to reduce to quoted market value .....	10,425.75	\$28,835.00
Unclipped matured coupons on bonds not in default .....	142.50	28,978.00
Deferred Charges		
Expense in connection with 1938 annual meeting .....		76.46
		\$32,282.39
Liabilities		
Note Payable		
To Lansing National Bank—secured—Note A .....		\$ 3,500.00
Accounts Payable		
For current expenses, etc. ....	\$2,853.53	
Advertiser's credit balance .....	2.00	2,855.53
Liability for Fund Administered		
Couzens' Foundation .....		39.37
Unearned Income		
Dues for the year 1938 .....		2,074.50
Reserve		
For Medico-Legal Defense Fund .....		12,048.60
Net Worth		
Balance at December 27, 1936 .....	\$19,738.92	
Net decrease for the year ended December 24, 1937 .....	7,974.53	11,764.39
		\$32,282.39

Note A—Securities in the principal amount of \$6,000.00 and having a quoted market value of \$6,042.50 were pledged to the Lansing National Bank as collateral security for a note payable.

# SOCIETY ACTIVITY

## INCOME AND EXPENSE STATEMENT FISCAL YEAR ENDED DECEMBER 24, 1937

Income	
Membership fees .....	\$38,953.50
Less: Allocated to Journal income for subscrip- tions .....	5,842.93
Allocated to Medico-Legal Defense Fund.....	1,949.07
	<u>\$ 7,792.00</u>

Net Income from Membership Fees.....	\$31,161.50
Income from Journal—as shown by schedule....	1,206.85
Interest received .....	959.76
Miscellaneous income .....	2.50

Total Income .....\$33,330.61

Expenses—as shown by schedule	
Administrative and general office.....	\$15,232.45
Society activities .....	15,563.75
Committee expenses .....	10,220.92
	<u>\$41,017.12</u>

Other Deductions	
Loss on sale of securities.....	\$ 3,817.33
Adjustment of inventory valuation.....	—0—
Interest paid .....	26.04
Bad accounts charged off or provided for, less recoveries .....	23.15
	<u>\$ 3,866.52</u>
	<u>\$44,883.64</u>

Net Loss or Income.....	\$11,553.03
Less adjustment of reserve to reduce securities of the General Fund to quoted market value..	3,578.50

Decrease or Increase in Net Worth....\$ 7,974.53

## EXPENSES FISCAL YEAR ENDED DECEMBER 24, 1937

Administrative and General	
Secretary's salary .....	\$ 2,400.00
Executive secretary's salary.....	6,000.00
Other office salaries .....	3,652.01
Office rent .....	720.00
Printing, stationery and supplies.....	685.28
Postage .....	639.15
Auditing .....	295.00
Insurance and fidelity bonds.....	185.25
Furniture and equipment purchased.....	138.26
Storage expense .....	—0—
Telephone and telegraph.....	376.42
Unclassified .....	141.08
	<u>\$15,232.45</u>

Society Activities	
Council expenses .....	\$ 2,729.19
Educational expenses .....	3,075.00
Delegates to American Medical Society.....	855.65
Secretaries' conference .....	851.41
Secretaries' letters .....	341.41
Traveling expense .....	1,449.80
Legal expense .....	750.00
Reporting annual meeting .....	115.37
Organization expense .....	3,225.54
Publications .....	1,441.16
Honorarium .....	500.00
Memorial plaque .....	—0—
Sundry society expense.....	539.00

\$15,873.53

Less revenue from annual meeting in excess  
of cost thereof..... 309.78

\$15,563.75

Committee Expenses	
Legislative committee .....	\$ 7,443.87
Postgraduate conference .....	1,631.62
Contribution to Joint Committee on Public Health Education .....	—0—
Economics committee .....	170.07
Maternal welfare committee.....	173.59
Public relations committee .....	70.59
Cancer committee .....	289.17
Preventive medicine committee.....	120.49
Goitre committee .....	—0—
Sundry other committees .....	321.52

\$10,220.92

Total .....\$41,017.12

## INCOME AND EXPENSES—"THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY" FISCAL YEAR ENDED DECEMBER 24, 1937

Income	
Subscriptions from members .....	\$ 5,842.93
Other subscriptions .....	121.53
Advertising .....	9,548.11
Reprint sales .....	2,029.08
Journal cuts .....	259.07
	<u>\$17,800.72</u>

Expenses	
Editor's salary .....	\$ 3,000.00
Editor's expense .....	600.00
Printing and mailing .....	9,965.04
Cost of reprints .....	1,597.60
Discount and commissions on advertising.....	1,181.23
Postage .....	250.00
	<u>\$16,593.87</u>

Net Income .....\$ 1,206.85

## RECEIPTS AND DISBURSEMENTS— JOINT COMMITTEE ON PUBLIC HEALTH EDUCATION FISCAL YEAR ENDED DECEMBER 24, 1937

Balance Due Joint Committee—December 27, 1936.....\$ 992.01

### Receipts

The Detroit News—for articles published .....\$ 999.96

Contribution:

Children's Fund of Michigan.....3,000.00 3,999.96

### Disbursements

Salaries: .....\$ 4,991.97

Mabel Kelly .....\$ 1,200.00

Herman Riecker, M. D.....900.00 \$ 2,100.00

Don E. Lyons, M. D.....100.00

Additional expense in connection with "Cancer" booklet published in 1936 in  
conjunction with Cancer Committee of the Michigan State Medical Society.. 43.12

Miscellaneous expenses paid on order of the Joint Committee.....988.08

Remitted to the Joint Committee.....1,760.77 4,991.97

Balance Due Joint Committee—December 24, 1937.....\$ —0—

## MEDICO-LEGAL DEFENSE FUND FISCAL YEAR ENDED DECEMBER 24, 1937

Balance—December 27, 1936 .....\$15,984.84

### Disbursements

Douglas, Barbour, Desenberg & Purdy—legal services.....\$ 3,146.98

Wm. J. Stapleton, Jr.—salary .....999.96

Miscellaneous .....77.85 \$ 4,224.79

### Receipts

Allocation of portion of dues income .....\$ 1,949.07

Interest received on securities .....558.41

2,507.48 1,717.31

Loss on securities sold.....\$ 2,132.43 \$14,267.53

Increase in allowance to reduce securities to quoted market value.....86.50 2,218.93

Balance—December 24, 1937 .....\$12,048.60

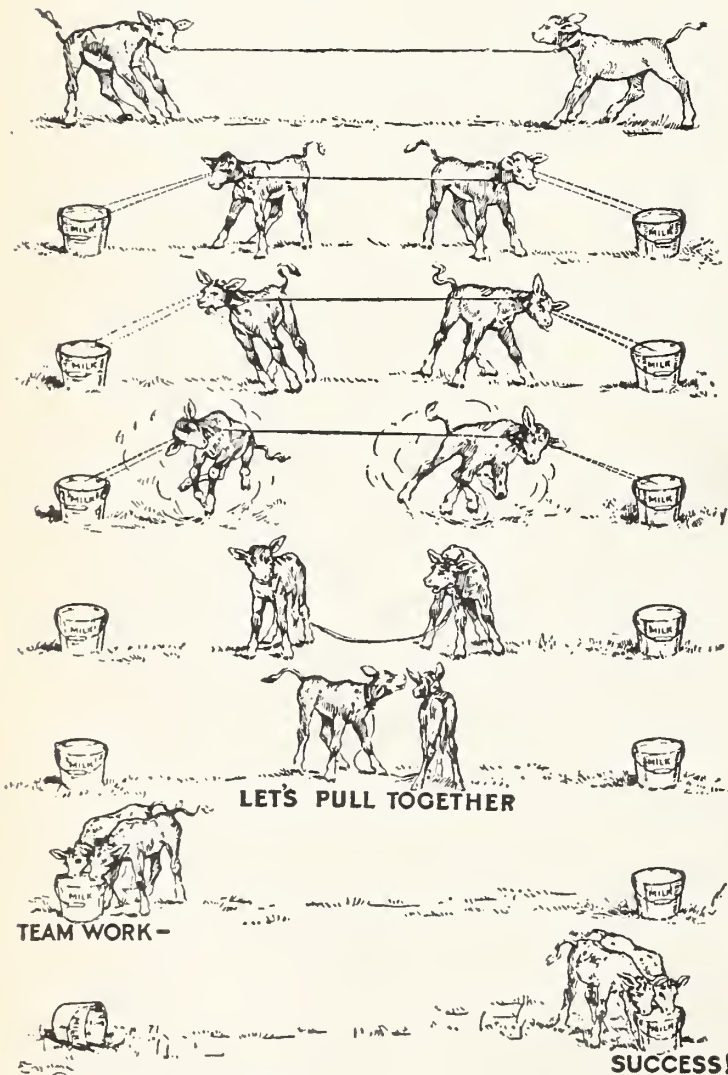
At December 29, 1937, the quoted market value of the securities allocated to the Medico-Legal Defense Fund exceeded the balance of this reserve account by the amount of \$990.90.



COUNCIL AND COMMITTEE MEETINGS

1. *Friday, January 7, 1938*—Advisory Committee to Parole Commission—State Prison of Southern Michigan, Jackson—11:00 a. m.
2. *Friday, January 7, 1938*—Advisory Committee on Tuberculosis Control—Olds Tower, Lansing—2:30 p. m.
3. *Sunday, January 9, 1938*—Preventive Medicine Committee—Hotel Durant, Flint—10:00 a. m.
4. *Sunday, January 9, 1938*—Advisory Committee on Syphilis Control—Hotel Durant, Flint—10:00 a. m.
5. *Tuesday, January 11, 1938*—Advisory Committee on Occupational Diseases—Hotel Statler, Detroit—6:30 p. m.
6. *Wednesday and Thursday, January 12-13, 1938*—Mid-Winter Meeting of The Council—Hotel Statler, Detroit.
7. *Saturday, January 22, 1938*—Public Relations Committee—Hotel Olds, Lansing—6:30 p. m.

TEAMWORK



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COUNTY SOCIETIES

BARRY COUNTY

THOMAS H. COBB, M.D.

*Secretary*

At the regular meeting of the Barry County Medical Society, December 9, 1937, the following officers were elected for the year 1938:

President—Dr. G. F. Fisher, Hastings.  
 Secretary and Treasurer—Dr. T. H. Cobb, Woodland.  
 Delegate—Dr. Robert Harkness, Hastings.  
 Alternate Delegate—Dr. H. S. Wedel, Freeport.

BAY COUNTY

A. L. ZILIAK, M.D.

*Secretary*

President A. D. Allen was host to the members and guests of the Bay County Medical Society at the Bay City Country Club for the annual meeting, Wednesday, December 15.

Dr. Allen provided a moose and venison dinner, the result of a recent hunting trip to the Canadian wilds.

The Michigan State Medical Society was represented by President Henry Cook of Flint, and Executive Secretary Wm. J. Burns, also Dr. P. R. Urmston, Chairman of the Council, and Dr. L. Fernald Foster, Secretary.

The following officers were elected for the ensuing year:

President—Dr. C. L. Hess, Bay City.  
 President-elect—Dr. L. Fernald Foster, Bay City.  
 Secretary and Treasurer—Dr. A. L. Ziliak, Bay City.  
 Delegate—Dr. R. C. Perkins, Bay City.  
 Alternate—Dr. A. D. Allen, Bay City.  
 Censor—Dr. R. N. Sherman, Bay City.  
 Medico-Legal Advisor—Dr. E. A. Witwer, Bay City.

The secretary's annual report showed an active membership of seventy-three, with two Emeritus and two Associate members.

The following programs were announced for January:

January 12—"Pneumonia." Dr. Gordon Myers, Detroit.

January 26—"Tuberculosis." Dr. John Barnwell, Ann Arbor.

Dr. Allen proved to be a delightful host at the annual meeting and continued the long custom of the society, whereby the retiring president provides the annual banquet.

BERRIEN COUNTY

A. F. BLIESMER, M.D.

*Secretary*

The newly elected officers of the Berrien County Medical Society for 1938 are:

President—Dr. Harry Kok, Benton Harbor.  
 Vice President—Dr. J. W. Gunn, Watervliet.  
 Secretary and Treasurer—Dr. A. F. Bliesmer, St. Joseph.  
 Delegate—Dr. Wm. Ellet, Benton Harbor.  
 Alternate—Dr. Fred Henderson, Niles.

## CALHOUN COUNTY

WILFRID HAUGHEY, M.D.

*Secretary*

The following officers were elected at the annual meeting of the Calhoun County Medical Society:

President—Dr. Joseph E. Rosenfeld, Battle Creek.  
Secretary—Dr. Wilfrid Haughey, Battle Creek.  
Delegates—Dr. Harvey Hansen, Battle Creek, and Dr. A. T. Hafford, Albion.  
Alternates—Dr. William Dugan, Battle Creek, and Dr. Norman H. Amos, Battle Creek.

## DELTA COUNTY

G. W. BENSON, M.D.

*Secretary*

At the annual meeting of the Delta County Medical Society held December 16, the following officers were elected for the year 1938:

President—Dr. W. A. Lemire, Escanaba.  
Vice President—Dr. O. S. Hult, Gladstone.  
Secretary—Dr. G. W. Benson, Escanaba.  
Delegate to State Convention—Dr. O. S. Hult.  
Alternate—Dr. G. W. Moll.  
Trustee of Society—Dr. J. D. Mitchell, Gladstone.

## DICKINSON-IRON COUNTY

W. H. HURON, M.D.

*Secretary*

The following officers were elected at the annual meeting of the Dickinson-Iron County Medical Society for 1938:

President—L. E. Irvine, M.D., Iron River.  
Vice President—R. E. Hayes, M.D., Sagola.  
Secretary—W. H. Huron, M.D., Iron Mountain.

## GENESEE COUNTY

C. W. COLWELL, M.D.

*Secretary*

The following are the officers of the Genesee County Medical Society for the year 1938:

President—Dr. Arthur McArthur, Flint.  
President-elect—Dr. Leon Bogart, Flint.  
Secretary—Dr. C. W. Colwell, Flint.  
Treasurer—Dr. Vaughn Morrissey, Flint.  
Medical Legal Officer—Dr. H. E. Randall, Flint.  
Delegates—Dr. F. E. Reeder, Flint; Dr. Robert Scott, Flint; Dr. Donald Brasie, Flint.  
Alternate Delegates—Dr. R. S. Halligan, Flint; Dr. Donald Wright, Flint; Dr. A. Dale Kirk, Flint.

## GRAND TRAVERSE-LEELANAU-BENZIE COUNTY

E. F. SLADEK, M.D.

*Secretary*

The annual meeting of the Grand Traverse-Leelanau-Benzie County Medical Society was held at the Park Place Hotel on December 7, 1937.

Thirty-one members and guests sat down to a banquet provided by the retiring president, Dr. Dwight Goodrich.

During the dinner hour we were enjoyably entertained by Dr. J. W. Moore of Flint who sang four songs: "The Open Road" by Ambrose; "Hom-ing" by Del Riego; "Star" by Roger, and "The End of a Perfect Day" by Carrie Jacobs Bond.

The Secretary-Treasurer's report was read.

The following officers were elected:

President—Dr. Mark Osterlin, Traverse City.  
Vice President—Dr. Frederick Trautman, Frankfort.  
Secretary and Treasurer—Dr. C. E. Lemen, Traverse City.  
Medico-Legal Advisor—Dr. Fred G. Swartz, Traverse City.

Dr. Henry Cook, president of the Michigan State Medical Society, was then welcomed as a most honored guest and spoke to us on "Unity in Medicine," particularly pointing out the much greater demands that are being made upon our profession and emphasizing coöperative and organized study and activity on the problems of governmental and socialized medicine, with due care given to preventive medicine. Dr. Cook insisted that we as a profession must pay especial attention to the problem of syphilis, because of the governmental campaign of lay education relative to this disease.

Dr. M. J. Holdsworth, of Grand Rapids, then gave us a very fine talk on "Gonorrhea in the Male," particularly emphasizing the question of when is the patient cured, and insisting that these patients must be treated for longer periods than is the general custom at the present time.

Dr. Leon M. Bogart, of Flint, gave a very illuminating and instructive talk on "Conditions Simulating an Acute Condition of the Abdomen," fearlessly emphasizing the various conditions spoken of by examples of mistakes which he had observed and made in his many years of practice. It was a personal talk of experiences and consequently far more impressionable. He also gave a talk on "The Use of Urea in the Treatment of Indolent Wounds," which was of a very practical nature.

A rising vote of thanks was given to our retiring president for this wonderful dinner and program which he provided, and to our guests who drove a long way to put on the program.

## HILLSDALE COUNTY

E. G. MCGAVRAN, M.D.

*Secretary*

The December meeting was called to order by the president, Dr. W. E. Alleger.

Due to the illness of the treasurer, Dr. Fenton, no treasurer's report was made, the secretary reading a communication from Dr. Fenton. Dr. Poppen and Dr. Green reported upon Dr. Fenton's condition. It was moved that the Society send another bouquet of flowers to Dr. Fenton and the secretary was so instructed.

Dr. Abraham's application for associate membership was presented by the secretary and unanimously voted.

Dr. H. W. Porter, as secretary of the Jackson Society, announced the State Officers Night for Hillsdale and Jackson Counties Tuesday, January 18, 1938, at 5:30 P.M.

The nominating committee composed of Drs. Green, Hanke, and C. T. Bower presented the following report:

President Emeritus—Dr. D. W. Fenton.  
President—Dr. W. E. Alleger.  
Vice President—Dr. A. W. Strom.  
Secretary—Dr. E. G. McGavran.  
Treasurer—Dr. E. A. Martindale.  
Delegate—Dr. L. W. Day.  
Alternate Delegate—Dr. H. F. Mattson.

The report of the committee was accepted. Dr. Van Schoick moved the By-Laws be suspended and the secretary instructed to cast a unanimous ballot for the officers named. Motion was seconded by Dr. M. H. Bowers. Passed.

The Health Department report was given by Dr. McGavran concerning the following items:



1. The use of penny postcards for the notification of meetings.
2. The new forms for reporting gonorrhea and syphilis.
3. The plan of counsellor calls upon the medical profession.
4. The matter of registration of the local laboratory.

The Maternity Committee report was given by Dr. A. W. Strom, who reported the progress of the home delivery service. Dr. Strom further presented a letter from the Birth Control League and recommended to the Program Committee that a meeting upon this subject with a talk and demonstration on modern methods of contraception be arranged at the earliest possible convenience and that the Hillsdale County list of physicians ready to render first class service in these matters be limited to those who would in the future take definite postgraduate time to prepare themselves in a good contraceptive clinic.

The report of the committee was approved by motion, seconded and unanimously voted upon.

The X-ray Committee report was given by Dr. M. H. Bowers. The new plan was presented. It was moved by Dr. Mattson that the report of the X-ray Committee be accepted.

Dr. Poppen asked for a meeting with ambulance drivers and that the Program Committee obtain Dr. Maddock from the University of Michigan on this occasion.

#### HOUGHTON-KEWEENAW-BARAGA COUNTY

C. A. COOPER, M.D.

##### *Secretary*

The Houghton-Keweenaw-Baraga County Medical Society at its annual meeting, held January 4, at the Douglass House, Houghton, elected the following officers:

President—Dr. R. S. Buckland, Baraga.  
 President-Elect—Dr. J. R. Kirton, Calumet.  
 Secretary—Dr. C. A. Cooper, Hancock.  
 Treasurer—Dr. W. T. King, Ahmeek.  
 Delegate—Dr. L. E. Coffin, Painesdale.  
 Alternate Delegate—Dr. G. M. Waldie, Hancock.  
 Members of Board of Ethics—(5 years) Dr. Simon Levin, Houghton; (3 years) Dr. J. B. Quick of Laurium.  
 Member of the Council—Dr. W. T. S. Gregg, Calumet.

#### INGHAM COUNTY

R. J. HIMMELBERGER, M.D.

##### *Secretary*

At its December Meeting, the Ingham County Medical Society elected the following officers:

President—Dr. Dana M. Snell.  
 President-Elect—Dr. L. G. Christian.  
 Secretary—Dr. R. J. Himmelberger.  
 Treasurer—Dr. T. I. Bauer.  
 Medical Director—Dr. H. Miller.  
 Delegates—Dr. R. L. Finch, Dr. C. F. DeVries and Dr. H. W. Wiley.  
 Alternate Delegates—Dr. H. M. Smith, Dr. O. B. McGillicuddy, and Dr. W. J. Cameron.

#### KENT COUNTY

JOHN M. WHALEN, M.D.

##### *Secretary*

The thirty-fifth annual dinner meeting of the Kent County Medical Society was held in the English Room of the Rowe Hotel, December 8, 1937, Dr. A. B. Smith, the retiring president, in the chair. One hundred twenty members were present.

Following the dinner and the reading of the annual reports by the various committee chairmen, the Society proceeded with the election of officers for the year 1938. The following officers were elected:

President—Abel J. Baker.  
 President-Elect—William R. Torgerson.  
 Vice President—Milner S. Ballard.  
 Secretary-Treasurer and Editor—John M. Whalen.  
 Councillor, Fifth District—Vernor M. Moore.  
 Defense League Representative—Joseph B. Whinery.  
 Delegates to State Society—A. V. Wenger, C. F. Snapp, P. W. Kniskern, G. H. Southwick, and W. R. Torgerson.  
 Alternate Delegates—O. H. Gillett, John Wenger, Paul Willits, Ward Ferguson, and J. F. Whinery.  
 Board of Directors—Joseph B. Whinery, Chairman, J. W. Riggerink, A. B. Smith, A. J. Baker, W. R. Torgerson and J. W. Whalen.

#### LIVINGSTON COUNTY

DUNCAN C. STEPHENS, M.D.

##### *Secretary*

The newly elected officers of the Livingston County Medical Society are:

President—Bernard H. Glenn, Fowlerville.  
 Secretary—D. C. Stephens, Howell.  
 Delegate—H. G. Huntington, Howell.  
 Alternate Delegate—J. J. Hendren, Fowlerville.

#### MASON COUNTY

C. A. PAUKSTIS, M.D.

##### *Secretary*

At a meeting of the Mason County Medical Society held Tuesday, January 4, 1938, election of officers took place and the following were elected:

President—Dr. V. J. Blanchette, Custer.  
 Secretary and Treasurer—Dr. C. A. Paukstis, Ludington.

Regular meetings will be held on the second Tuesday of each month and annual election will take place in December.

#### NEWAYGO COUNTY

W. H. BARNUM, M.D.

##### *Secretary*

The annual meeting of the Newaygo County Medical Society was held at the Kimbark Inn, December 17, 1937, with dinner served at 7:00 p. m.

The minutes of the last meeting were read and approved by motion.

Dr. Roy H. Holmes, Muskegon, councillor of the 11th District, gave the Society a synopsis of the legal aspect of the medical topics, as following the last State Society.

Dr. T. R. Deur of Grant, and Dr. Samuel Stevens of Bitely, were voted to membership in the society.

The election of officers for the ensuing year resulted as follows:

President—Lambert Geerlings, Fremont.  
 Secretary—W. H. Barnum, Fremont.  
 Delegate—O. D. Stryker, Fremont.  
 Alternate Delegate—W. H. Barnum, Fremont.  
 The meeting adjourned.

#### OTTAWA COUNTY

K. N. WELLS, M.D.

##### *Secretary*

At the December meeting of the Ottawa County Medical Association the following officers were elected:

President—Dr. Gerritt Kemme, Zeeland.  
 Vice President—Dr. Otto Vander Velde, Holland.  
 Secretary and Treasurer—Dr. D. C. Bloemendal, Zeeland.

## ONTONAGON COUNTY

E. J. EVANS, M.D.  
*Secretary*

The Ontonagon County Medical Society elected the following officers for 1938:

President—F. W. McHugh, M.D., Ontonagon.  
Vice President—W. F. Strong, M.D., Ontonagon.  
Secretary and Treasurer—E. J. Evans, M.D., Ontonagon.  
Delegate—E. J. Evans, M.D., Ontonagon.  
Alternate—C. C. Corkill, M.D., Ontonagon.  
Trustee for three years—S. H. Rubinfeld, M.D., Ontonagon.

## ST. CLAIR COUNTY

JACOB H. BURLEY, M.D.  
*Secretary*

The annual meeting of the St. Clair Medical Association was held Tuesday, December 21, at St. Clair. The following officers were elected:

President—Dr. Charlton H. MacPherson, St. Clair.  
Secretary—Dr. Jacob H. Burley, Port Huron.

## WASHTENAW COUNTY

L. J. JOHNSON, M.D.  
*Secretary*

The December meeting of the Washtenaw County Medical Society was held at the Michigan Union at 6:00 o'clock p. m., December 14, 1937, Dr. Reed Nesbit, president, presiding.

A letter on "Committees and Physicians" from the Michigan State Medical Society was also read.

The Censor Committee presented the applications of Harold W. Riggs, Paul Dirkse and Willis E. Brown. They were unanimously elected to membership.

The report of the Public Relations Committee was read by Dr. McEachern and has been filed in the records. Copies of this report were sent to Lois Heitman, County Agent, and Dr. Foster, secretary of the Michigan State Medical Society.

Dr. Wessinger, in reporting for the Delegates to the State Convention, stated that the activities of the House of Delegates were published in the State Journal. Dr. Wessinger, in reporting as Chairman of the Censor Committee, stated that the Washtenaw County Medical Society had endorsed the new birth reports but had refused to endorse the reports on stillbirth. His reports were unanimously accepted.

Dr. Ross reported for the Red Cross Committee and his report was unanimously accepted.

Dr. Waldron, in reporting for the Nominating

Committee, added the name of Dr. L. J. Johnson to the list of Delegates to the State Society. The alternates were Dr. Williamson, Dr. DeTar and Dr. Fralick. There were no motions made from the floor and it was moved and seconded that the nominations be closed. Carried. Dr. Waldron moved that the Secretary be instructed to cast a ballot for Dr. John W. Kemper, President Elect, Dr. William Brace, secretary and treasurer, Dr. Lee Knoll as Member of the Board of Censors, Doctors Wessinger, Myers and Johnson as Delegates to the State Society and Doctors Williamson, DeTar and Fralick as Alternates. Seconded and unanimously carried.

Dr. Nesbit appointed as Auditing Committee Dr. Rigdon Ratliff and Dr. Hugh Beebe.

At this point in the meeting Dr. Nesbit turned the gavel over to the newly elected president, Dr. Sidney LaFever. In accepting the gavel Dr. LaFever thanked the members of the Society for the honor of his position and asked the Membership if it approved of the business activities being cared for by the Board of Directors so that the regular meetings could devote more time to the scientific program. This met with approval and Dr. Cummings suggested that short reports of the activities of the Board of Directors be read at each meeting.

The scientific part of the program was given by Dr. Walter G. Maddock, who presented a most interesting paper on intestinal obstruction. This timely paper was discussed by Drs. Malcolm, George, and Marshall.

The meeting adjourned at 8:30 o'clock p. m.

## WEXFORD COUNTY

B. A. HOLM, M.D.  
*Secretary*

At our last regular meeting, November 11, 1937, the following officers were elected for the coming year:

President—Dr. L. E. Showalter, Cadillac.  
Secretary and Treasurer—Dr. Benton A. Holm, Cadillac.  
First Vice President—Dr. J. F. Carrow, Marion.  
Second Vice President—Dr. Ralph Hager, Banton.  
Delegate to State Convention—Dr. W. J. Smith, Cadillac.  
Alternate to State Convention—Dr. J. F. Gruber, Cadillac.  
Legal Committee—Dr. J. F. Carrow, Marion, and Dr. G. P. Moore, Cadillac.  
Contract Committee—Dr. L. E. Showalter, Cadillac, and Dr. E. A. McManus, Mesick.  
Finance Committee—Dr. S. C. Moore, Cadillac.  
Program Committee—Dr. B. A. Holm, Dr. M. R. Murphy, and Dr. S. C. Moore, Cadillac.  
Public Relations Committee—Dr. J. H. McCall, Lake City; Dr. Ralph Hager, Manton; Dr. J. F. Carrow, Marion, and Dr. H. C. Buster, Baldwin.  
Membership Committee—Dr. R. W. Albi, Lake City; Dr. E. A. McManus, Mesick, and Dr. B. A. Holm, Cadillac.

## GOLFERS' SPECIAL TO 'FRISCO

for the A.M.A. Convention, June 13-17, 1938

New Orleans—Houston—Galveston—San Antonio—Los Angeles—Del Monte—San Francisco!

Return thru Portland—Seattle—Vancouver—Lake Louise—Banff!

Nine Games of Golf—Sightseeing—Entertainment—a Day with Hollywood Stars

Non-golfers as well as golfers (and their ladies) invited.

YOU OWE YOURSELF THIS WONDERFUL TRIP

Under sponsorship of the American Medical Golfing Association. For itinerary and further information drop a card to Dr. Walt P. Conaway, Pres., AMGA, 1723 Pacific Ave., Atlantic City, N. J.



## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### ADVISORY COMMITTEE RECOMMENDATIONS

The Advisory Committee to the Woman's Auxiliary, at their meeting on November 17, 1937, made the following recommendations to the Auxiliary for the following year:

(a) The organization of a local Woman's Auxiliary in each County. Some able and willing doctor's wife to be designated to start the organization. Someone from the State organization who is experienced in organization work should be sent to help her.

(b) That every Auxiliary member be a good Club Woman, belonging to as many community groups as possible, attending meetings regularly, taking to the meetings and bringing from the meetings such information as will help her Auxiliary and her husband's profession. If she is gifted in public speaking, she should speak to the various Woman's Clubs, P.T.A.'s, et cetera.

(c) That every woman inform herself on State Medicine so that she can talk intelligently on this subject and give the medical point of view.

(d) That the members of the Auxiliary become interested as individuals in the Michigan Health League and become members of this organization, also use their influence to interest wives of prominent men in the community in the Michigan Health League.

(e) That the Woman's Auxiliary assist the State Medical Society in its program of public health education, promoting radio health programs sponsored by the medical society and helping develop a conscience minded public toward health problems.

(Mrs. J. W.) ETHEL BOYD PAGE,  
State Secretary-Treasurer.

### HYGEIA AND THE AUXILIARY

The name *hygeia* was taken from Grecian Mythology, being the name of the Mythological Goddess of Health, daughter of Aesculapius, the son of Apollo. The name proves to be well-chosen, and as the patron of the physician is Aesculapius would it not be fitting to think of *hygeia* as the patron of the nurse? Let's give *hygeia* a real chance to nurse back to normal those with wrong ideas about health and healing. For indeed one of the most important problems confronting the physician and his family today is the way the general public accepts the authentic scientific health information of the medical profession against the conjured theories of "Quacks" and "Cults."

One needs only to read the local newspaper or many of our current magazines to realize the need for *hygeia*. It is evident that fantastic mysteries, cults, and cures, as in the days of the medicine man, are not a thing of the past. Your local newspaper patent medicine advertisement reads as though it were written to interest the uncivilized, or those whose minds were still darkened by superstition. I quote: "PenORub—Rubs out pain when children fall, bump or bruise themselves—ease the inflammation, the distress and swelling by cool refreshing PenORub—Fast relief—only 35c." In striking contrast to this statement *Hygeia* tells us that untrained efforts in injury or accident may cause great damage and make an accident many times more serious than it might otherwise have been.

When one reads the, too numerous to mention, remedies and sure cures for all that ails "baby" we can't fail to realize the need for sound advice on this subject. The inspiring article published in the May 1936 *Hygeia* on "Child Health" clearly sets forth that life is most precarious in its earliest hours and days. And anyone who read this article would, I am sure, feel the necessity of being directed in matters of health by one who has devoted his life to the help of humanity, the Physician. It is an inspiration to know that the medical profession never keeps secret the discoveries and advancements which go to make this world a better place in which to live.

May I pause here for you to ask yourself these questions which have been asked me:

1. Ques: Does the reading of *Hygeia* really do the patient any good?  
Ans: Yes, indeed! It teaches facts about health, not fallacies.
2. Ques: Do you think *Hygeia* causes the patient to practice medicine for himself thereby causing the physicians not to be consulted?  
Ans: I do not, since only enough symptomatology is given in *Hygeia* to afford the reader the ability to differentiate between normal and abnormal conditions. I am not aware of a single issue which has not pointed out the dangers of self-diagnosis and the necessity of immediately obtaining the counsel and advice of a competent physician.
3. Ques: Don't you think *Hygeia* is too high?  
Ans: The advice of the medical profession, scientific, workable, and authentic is not high at any price. How could it be when there is nothing more priceless than health.
4. Ques: Do you think a physician's wife should solicit for *Hygeia* and do you not think it places her in the position of a magazine saleswoman?  
Ans: As long as most of us are inescapably involved in a common destiny, and as long as coöperation is not a sentiment but an economic necessity, there can be nothing wrong with physicians' wives working in coöperation for a common cause as dignified as *Hygeia*. There is an old proverb which says "Despise not any man, nor spurn anything; for there is no man that has not his hour, nor is there anything that has not its place."
5. Ques: Why don't all the doctors subscribe to articles in *Hygeia*?  
Ans: Why don't all doctors agree? Well-trained physicians use the same treatment wherever a real cure has been found—a specific for disease is quite generally used—all kinds of physicians use antitoxin for diphtheria—all kinds of doctors set a leg when it is broken—but in diseases where the exact cause is unknown or the best treatment is a matter of personal diagnosis then everyone has a right to his own opinion. But doctors do agree on one thing, that is a longing to help the sufferer. They constantly seek the truth, so that they can rightly qualify as their brother's keeper. They have taken their profession into their hearts as well as upon their shoulders.

There is no doubt but that we, in our work, are unmistakably and inescapably involved in a common destiny in which coöperation IS an economic necessity, NOT a sentiment. We need the unity of all for a single cause each playing his part for the general good of everyone. To cherish our organization as part of ourselves, we should be staunch, loyal, and true—be comrades. The sad side of any organization's life is when straining at the rules breaks the spirit of the group. Let's not seek selfish ends at any cost to others, prefer our vain glory rather than an achievement of common good, or shut our hearts to the troubles of others. If



we are to have a world where only a flower of life can grow and flourish, we must first see to it that the weeds are transformed into flowers or that the seeds of weeds are destroyed before life begins again. Let everyone of us pull together and let no one pull back.

Read before the Davidson County Medical Society by Mrs. James Dunn Lester, February, 1937, Hygeia Chairman to Woman's Auxiliary to A.M.A.

## COUNTY AUXILIARIES

### Ingham County

On November 30 the Ingham County Auxiliary sponsored a lecture on "Popular Beliefs That Are Not So," with Dr. Paul Leschner as the lecturer. The meeting was open to the public with 500 present.

Two Yuletide events were planned by the Auxiliary—a tea, December 13, at the home of Mrs. D. A. Galbraith; and a Children's Party, December 18, at St. Paul's Episcopal Guild Hall. Mrs. Karl Brucker and Mrs. Walter Maner presented a dramatic reading with musical setting.

MRS. P. C. STRAUSS,  
*Press Chairman.*

### Jackson County

The Jackson County Medical Society entertained their wives and guests at the Annual Banquet and Dance at the Hotel Hayes, Thursday evening, December 16. Dr. R. H. Alter presided as toastmaster. He introduced Dr. E. D. Crowley, the outgoing president, and his wife; Dr. John Van Schoick of Hanover, the new president, and his wife; and Dr. G. R. Bullen, president-elect for 1939, and his wife. Dr. Crowley handed the gavel over to his successor, Dr. Van Schoick, each making a few appropriate remarks. The ladies' places at the table were marked by beautiful corsages, the gift of the Chemist Shop. Delightful solo numbers were given by Miss Virginia Solomon, a Jackson violin virtuoso. She reappeared twice in response to the hearty applause and was generous in her encores. She was accompanied by Mr. Edgar Crowle. The remainder of the evening was spent in dancing, the music for both dinner and dance being furnished by Art Winter's orchestra.

ANNA HYDE SHAEFFER,  
*Press Chairman.*

### Kalamazoo

The Kalamazoo Academy of Medicine was host to its Auxiliary at their annual dinner, Tuesday, December 21, 1937, at the Park American Hotel, with attendance of 135. Beautiful spring flowers centered the tables, which were presented to ladies of local and state officers.

Among the honored guests was Dr. A. H. Rockwell, honorary member. Dr. Rockwell, who is eighty-seven years old, graduated from the Medical School, University of Michigan, fifty-four years ago, practiced in Kalamazoo forty-nine years and served twenty-two years as director of public health.

Dr. R. J. Hubbell, newly elected president of the Academy, spoke briefly, and Mrs. W. W. Lang, president of the Auxiliary, was introduced and extended greetings.

The retiring president, Dr. W. G. Hoebeke, gave the exaugural address on "The Art of Medicine," dealing with the human relationship existing between doctor and patient.

The Academy paid tribute to the late Dr. A. W. Crane in a paper prepared and read by Dr. W. C. Huyser. Dr. Huyser ably sketched the life of Dr. Crane, who rose from an obscure practitioner to

international preëminence as a roentgenologist. Dr. Huyser also told of the work in sanitation done by the late Dr. Caroline Bartlett Crane, wife of Dr. A. W. Crane. This won wide recognition and led to her being made an associate member of the Academy of Medicine. Dr. Caroline B. Crane was a member of this Auxiliary and one of its founders. She also was the Organizer of the State Auxiliary.

Members of the Auxiliary brought gifts for the aged to be distributed at the Community Christmas tree.

(MRS. HUGO) BARBARA K. AACH,  
*Publicity Chairman.*

### Kent County

On December 18, about two hundred of the doctors and their wives gathered at the Pantlind ballrooms after having attended various pre-dinner parties. The dinner dance was a colorful and entertaining affair. Phil Osterhouse introduced the group to the intricacies of The Big Apple. Mrs. M. W. Shellman and her committee well earned the pleased comments of the group.

The *Hygeia* committee, under the chairmanship of Mrs. William Butler, is working hard to make every member of the auxiliary a subscriber to *Hygeia* before the end of January. Mrs. John Whalen's Philanthropic committee have worked with the *Hygeia* committee on the two money-making projects this fall, the rummage sale and the benefit bridge, which netted the handsome total of \$191.00.

The women are very grateful to the Medical Society for a whole page in the *Kent County Bulletin*. This bulletin is published twice a month and each copy will have a full page of Auxiliary news.

Respectfully submitted,  
(MRS. ROBERT M.) MIRIAM ADAMS EATON.

### Monroe

The opening meeting of the Monroe County Medical Auxiliary was held at Miss Dunk's Tea Room, with sixteen members present for the usual six-thirty dinner. Due to the illness of our president, Mrs. Albert Reisig, our vice president, Mrs. T. A. McDonald, presided.

Reports were read by the secretary, Mrs. E. C. Long; treasurer, Mrs. M. A. Hunter; Program and Social Committees chairman, Mrs. W. W. Bond, and Membership Committee chairman, Mrs. R. J. Williams.

After an hour's informal discussion, the meeting was adjourned.

\* \* \*

The November meeting at the Monroe Country Club, November 18, was preceded by a dinner served to thirty members and guests. In the absence of our president, the vice president, Mrs. T. A. McDonald, presided.

Our Program chairman, Mrs. W. W. Bond, introduced the speaker of the evening, Dr. S. E. Gould, pathologist at Eloise Hospital, Eloise, Mich., who spoke to us on the subject, "What Everyone Should Know About Cancer." The meeting was open to the public.

Dr. Gould gave an interesting and enlightening talk on this subject, stressing the fact that people must be educated to immediately see a doctor, when there is the slightest suspicion of a growth.

Officers for the year are: President, Mrs. A. H. Reisig; vice president, Mrs. T. A. McDonald; secretary, Mrs. Edgar C. Long, and treasurer, Mrs. M. A. Hunter, all of Monroe.

(MRS. VINCENT) MARTHA BARKER,  
*Press Chairman.*



## MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

### A REVIEW OF HEALTH PROGRESS IN 1937

A review of health conditions in Michigan during 1937, based upon unofficial statistics for the first ten months of that period, indicates an encouraging trend. The general death rate, the infant mortality rate, and the maternal mortality rate declined over comparable figures for the preceding year. Practically all of the major causes of death either remained stationary or showed definite increases.

All time low records for infant deaths and for deaths of mothers from causes incident to childbirth have been recorded for the first ten months of 1937. Equally low rates are expected when the final official statistics are compiled for the entire year. The infant mortality rate for the first ten months is 48.73 compared with a rate of 51.57 per 1,000 live births the previous year. A total of 3,655 infant deaths for the ten months compares with 3,850 in 1936.

Maternal mortality declined 25 per cent in 1937—the greatest single decrease in recent years. The new low rate for this period of 3.68 deaths per 1,000 live births compares with the 1936 rate of 4.96. There were 276 maternal deaths in ten months of 1937 compared with 370 in 1936.

The general death rate also shows an encouraging decline for 1937. A total of 44,655 deaths during ten months of 1937 means a 3 per cent drop in Michigan's death rate compared with 45,978 recorded the previous year. The death rate during this period is 10.55 per 1,000 population compared with 10.87 in the same period of 1936.

The birth rate also continued its slow rise from the depression-low point which was 15.96 in 1933. The birth rate during the past year reached 17.73 per 1,000 population compared with 17.65 in 1936. There have been 75,012 births recorded for the ten-month period compared with 74,661 in 1936.

Heart disease and cancer, the two major causes of death which have been increasing constantly for a decade, came to a halt in 1937 and showed definite decreases. The total of 7,994 deaths from heart disease is 454 less than in the same period of 1936. Cancer deaths totaled 4,563 compared with 4,649 in 1936. Deaths from apoplexy, nephritis and accidents (exclusive of automobile) declined greatly. Diabetes and pneumonia mortality show slight declines. It is the first time in recent years that pneumonia deaths have not increased. Typhoid fever deaths reached a new low figure in 1937, and diarrhea and enteritis deaths among children decreased 44 per cent.

The rather constant drop in tuberculosis mortality appears definitely to have come to a halt. For the second successive year deaths from this cause have increased slightly; 1,797 deaths have been reported in the ten-month period against 1,762 the previous year.

Deaths caused by automobiles showed the greatest increase of all in 1937. The total of 1,804 deaths for ten months is running 22 per cent ahead of the all-time high mortality recorded in 1936. By the end of November, 1,966 deaths had been caused by automobiles—already topping the 1,913 deaths for the entire previous year.

Two communicable disease outbreaks attracted

major attention in 1937. The trichinosis outbreak at Capac was reported to be one of the largest ever observed. The Monroe county outbreak of smallpox accounted for almost all of the cases of this disease occurring in Michigan during the past year and emphasized again the need for continued vaccination programs as the only means of prevention. Diphtheria and scarlet fever, too, were unusually prevalent in 1937. Deaths from diphtheria increased from 32 to 56.

The extensive maternal and child health program conducted by the department in 1937 with the aid of Social Security funds was carried out in close coöperation with local medical societies. This program included refresher courses in pediatrics and obstetrics for physicians in Northern Michigan and the Upper Peninsula, the furnishing of public health nursing services to 21 counties heretofore not provided with this service, renewed emphasis on nutrition, the development of an experimental home delivery service, and the conduct of a state-wide educational program which reached 99,292 women and girls in health classes conducted by staff physicians.

In the field of public health organization, the development and supervision of local, full-time health departments continued to be a major project of the Michigan Department of Health in 1937. At present 56 of the 83 counties are provided with such departments, serving 55 per cent of the rural population. Including the ten major city health departments, full-time health departments are now serving 73 per cent of Michigan's total population.

Since Social Security funds became available in the spring of 1936, a total of seventeen counties in the rural areas of Northern Michigan have been aided in organizing county or district health departments. Counties which have recently formed either single county or district health departments with the aid of federal funds allocated by the Michigan Department of Health include Alger, Schoolcraft, Keweenaw, Iron, Mason, Manistee, Mecosta, Oscoda, Menominee, Ontonagon, Baraga and Sanilac.

In coöperation with the Advisory Committee on Syphilis Control of the Michigan State Medical Society, the department, in 1937, launched a broad syphilis control program. New rules and regulations have been adopted as one measure for securing isolation and prompt, continuous treatment of infectious cases of syphilis. Curative drugs are being distributed free of charge to physicians whose patients cannot afford them; diagnostic laboratory services have been expanded to meet the needs of physicians; and a special division of syphilis control has been created to administer the program. New and more convenient venereal disease report forms have been provided, and suggested outlines for the treatment of syphilis prepared by the Michigan State Medical Society have been printed for general distribution.

The promotion of a state tuberculosis control program has been a major department activity in 1937. This program has been aided greatly by the modernizing of Michigan's tuberculosis laws by the last legislature. Intensive case finding campaigns utilizing improved diagnostic methods and applying active treatment to early cases are being conducted by local health departments under the supervision of the Division of Tuberculosis.

The department's preliminary pneumonia control program, based upon the development and free distribution of antipneumococcic sera to physicians made progress in 1937. The potency and safety of the department's sera has been extensively tested and the product is ready for general distribution if

*(Continued on page 184)*

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additional funds become available. A trained epidemiologist has been assigned to direct the department's control program.

Dedication of the new \$250,000 diagnostic laboratories of the department in 1937 marked the fiftieth anniversary of public health laboratory service in CALLERY ... Jan 7—Michigan. The new laboratories provide more rapid and extensive diagnostic services for physicians and health officers. In November, 1937, the laboratories performed 37,237 examinations compared to 25,561 in the same month of 1936—a 45 per cent increase.

The department laboratories in 1937 made arrangements to care for the majority of tests for venereal disease which have been necessitated by passage of the Antenuptial Physical Examination Law. In addition to making the required examinations, the laboratories are charged with the constant checking of the 125 registered laboratories approved for serodiagnosis of syphilis. Since the new marriage law went into effect on October 29, the laboratories have found positive indications of syphilis in approximately 1 per cent of the specimens examined.

Michigan, in 1937, witnessed a year of unprecedented activity in the field of sanitary engineering. With the aid of federal funds many communities have constructed long-needed improvements to water supply and sewage disposal systems. Plans, construction and maintenance of these plants are supervised by the department's Bureau of Engineering. New water treatment plants have been placed in operation during the past year at Algonac, Ann Arbor, Big Rapids, Marine City, Muskegon, New Baltimore, Owosso and Pinconning. Extensive repairs and enlargements to plants have been made at Bay City, Benton Harbor, Harbor Beach, Highland Park, Midland and Ramsay. A total of 339 public water supplies are now being supervised by the department.

During 1937, thirteen new sewage treatment plants have been completed and placed in operation. A population of over 2,700,000 is now being served by adequate sewage treatment systems. Plants are now under construction and will be completed during the coming year at Cass City, South Lyon, Sandusky, Detroit and Lansing. Eleven artificial swimming pools were constructed in 1937 with the approval of the department and 1,800 resorts were inspected by local sanitarians and certified by the department.

Michigan's industrial hygiene program got under way in 1937 with extensive surveys being made of all foundries, paper mills and furniture factories. Operators of these plants have been informed of results of these surveys, of possible occupational hazards, the number of employees subject to possible hazards, signs and symptoms of diseases which might occur, and methods for preventing known occupational hazards. Similar surveys are being conducted in the chromium plating, stone cutting, dry cleaning and printing industries. The occupational disease reporting law, which became effective in 1937, is being administered by the Bureau of Industrial Hygiene. Physicians are now required to report cases of occupational disease, thus making it possible to determine from this data the sources of greatest danger to industrial workers.

Thus, with declining mortality rates, the passage of significant health legislation, increased maternal and child health protection, improved communicable disease control, and the further extension of health services into rural areas of the state, the Michigan Department of Health completes its sixty-fifth year of public health service.

## IN MEMORIAM

### Dr. William S. Brownell

Dr. William S. Brownell of Detroit died on January 24, 1938. He was born sixty-nine years ago at Utica, Michigan, and was the son of Dr. William Brownell, a major in the Civil War. He was a graduate of the University of Michigan and the Detroit College of Medicine, and had practiced in Detroit since 1890. During the World War, he was a captain in the medical corps. Dr. Brownell gave up most of his activities six years ago when he became ill. He had been a member of the Wayne County Medical Society. He is survived by his wife, Mrs. Elsi Cain Brownell, and a sister, Miss Katherine Brownell, of Utica.

### Dr. John W. Hauxhurst

Dr. John W. Hauxhurst of Bay City died on January 22, 1938. He suffered an apoplectic stroke earlier in the week and never regained consciousness. Dr. Hauxhurst was born in 1848 at Jericho, New York. When a young man, he left home to teach school in Booneville, Missouri, but later entered the University of Michigan Medical School where he graduated in 1876. He had practiced continuously in Bay City since that time. He was a charter member and past-president of the Bay County Medical Society, a member of the Michigan State Medical Society and the American Medical Association. He was honored by the Bay County Medical Society on his fiftieth year in practice. Surviving Dr. Hauxhurst are his widow, a son, Henry Austin Hauxhurst of Cleveland, and a daughter, Miss Florence Hauxhurst.

### Dr. William Grant Bird

Dr. William Grant Bird of Flint died on January 21, 1938. He was born June 6, 1868, at Eagle Harbor, Michigan, and later lived at Romulus, Michigan. He was graduated from the Detroit College of Medicine in 1895 and began general practice in Milford. In 1900, Dr. Bird limited his practice to diseases of the eye, ear, nose and throat, and opened an office in Flint. He was a member of the Genesee County Medical Society, the Michigan State and American Medical Associations, and a Fellow of the American College of Surgeons. He was a past-president of the Genesee County Medical Society and served as Councillor for the sixth district of the Michigan State Medical Society for two years. Dr. Bird took extensive post-graduate work in medical centers in this country and in Vienna and London. He is survived by William Carroll Bird, the son from his first marriage; Mrs. Bird and their son, John Grant Bird, and daughter, Miss Josephine Ann Bird.

### Dr. Allison B. Toaz

Dr. Allison B. Toaz of Detroit was instantly killed at noon on January 31, 1938, when his automobile collided with a truck near Detroit. He was fifty-one years of age. Dr. Toaz was a graduate of the medical department of Wayne University of the class of 1914. He had been practicing in Detroit since his graduation. Dr. Toaz was a member of the staff of Woman's Hospital, Providence Hospital and the Booth Memorial Hospital, Detroit. He is survived by his wife and five children, Phyllis, a student at Albion College; Robert, a student at Western Reserve University Medical School, Cleveland; Jean, a student at Ypsilanti State Normal College; Richard and Warren.

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## ◆ General News and Announcements ◆

### *The One Hundred Per Cent Club of the Michigan State Medical Society*

1. Ingham County Medical Society
2. Luce County Medical Society
3. Muskegon County Medical Society
4. Newaygo County Medical Society
5. Ontonagon County Medical Society
6. Shiawassee County Medical Society

These six county medical societies are the first to record 100 per cent paid membership for the year 1938. Dues for 1938 are now payable and are being received daily from the various county medical society secretaries. See your County Secretary today and help your Society become one of the first members of the "One Hundred Per Cent Club for 1938."

*Dr. Walter J. Cree* of Detroit is spending several months in Florida.

\* \* \*

*The Milwaukee Sanitarium* of Wauwatosa, Wis., announces the appointment of *Dr. Lloyd A. Ziegler* as Associate Medical Instructor.

\* \* \*

Before signing an order with detail men, ask them if they advertise in *THE JOURNAL* of the M.S.M.S., and if they exhibit at the annual session of the Michigan State Medical Society.

\* \* \*

*F. W. Hartman, M.D.*, Detroit, is the author of an original article in the *Jour. A.M.A.*, issue of December 25, 1937, entitled "Lesions of the Brain Following Fever Therapy: Etiology and Pathogenesis."

\* \* \*

*Secretary L. Fernald Foster* spoke before the joint meeting of the St. Clair County Medical Society and the St. Clair Bar Association in Port Huron on January 18. His subject was "Professional Coöperation and Advancement."

\* \* \*

*Walter G. Maddock, M.D.*, *Svend Pedersen, Ph.D.* and *Frederick A. Collier, M.D.*, of Ann Arbor, are authors of an article in the *Jour. A.M.A.*, December 25, 1937, issue, entitled "Studies of the Blood Chemistry in Thyroid Crisis."

\* \* \*

*Burt R. Shurly, M.D.*, of Detroit, is the author of an original article in the *Journal of the American Medical Association*, issue of December 18, 1937, entitled "Otolaryngology in Relation to General Medicine."

\* \* \*

*The Wayne County Medical Society*, in the Detroit Medical News, publishes each year a list of new members. The 1937 list totalled 182 names, including 55 reinstatements to senior active membership.

\* \* \*

*The Ohio State Medical Association* is sponsoring a Special Train to the 1938 session of the American Medical Association in San Francisco next June. For further information on the Ohio-A.M.A. special train, write *C. S. Nelson*, Executive Secretary, Hartman Theatre Building, Columbus, Ohio.

\* \* \*

*Senator D. Hale Brake* of Stanton was guest speaker before the Battle Creek Academy of Medi-

cine and Dentistry on January 25. He explained the 1937 Welfare Laws of Michigan, which will be the subject of a referendum next November. Executive Secretary *Wm. J. Burns* introduced Senator *Brake* to the seventy-five physicians and dentists present.

\* \* \*

*Dr. L. O. Schantz* of Flint has been appointed Medical Coordinator for the county of Genesee in connection with the Afflicted Child Act. His duties will be to check on the medical necessity of those cases applying under this law, and to follow all cases committed by the courts through the period of hospitalization in any hospital in Genesee County. *Dr. Schantz* was appointed on December 1 by Auditor General *George T. Gundry*.

\* \* \*

*Dr. Henry E. Perry* of Newberry, immediate past president of the Michigan State Medical Society, was honored by the members of the Luce County Medical Society at a meeting at Doctor *Perry's* home on January 11. During the meeting, Doctor *Perry* was presented with a fine Gladstone bag in recognition of services rendered as president of the Michigan State Medical Society. *Dr. F. C. Bandy* of Sault St. Marie, Councilor for the Twelfth District, was present. *Dr. Perry* and his daughter, *Jean Barbara*, left for the sunny climate of Florida on the 15th of the month.

\* \* \*

*The members of the Advisory Committee on Syphilis Control* are: Chairman *Loren W. Shaffer, M.D.*, Detroit; *Robt. S. Breakey, M.D.*, Lansing; *R. S. Dixon, M.D.*, Detroit; *George Hays, M.D.*, Flint; *R. H. Holmes, M.D.*, Muskegon; *Wm. A. Hyland, M.D.*, Grand Rapids; *John Lavan, M.D.*, Grand Rapids; *C. K. Valade, M.D.*, Detroit and *Udo J. Wile, M.D.*, Ann Arbor.

*The members of the Advisory Committee on Tuberculosis Control* are: Chairman *Bruce H. Douglas, M.D.*, Detroit; *Robt. B. Harkness, M.D.*, Hastings; *George A. Sherman, M.D.*, Pontiac; *G. C. Stucky, M.D.*, Lansing; *B. A. Shepard, M.D.*, Kalamazoo; *E. R. Witwer, M.D.*, Detroit and *A. W. Newitt, M.D.*, Lansing.

\* \* \*

### **Staff of Butterworth Hospital**

Medical staff of Butterworth Hospital, Grand Rapids, reelected *Dr. Harrison C. Collisi* chief of staff, and *Dr. Leland M. McKinley* vice chief of staff at their annual meeting. *Dr. A. J. Baker* succeeded *Dr. James S. Brotherhood* as chief of medicine.

Other departmental chiefs, all reelected, are as follows: Chief of surgery, *Dr. G. Howard Southwick*; chief of gynecology, *Dr. J. Clinton Foshee*; chief of obstetrics, *Dr. Leon C. Bosch*; chief of eye, ear, nose and throat, *Dr. Henry Blackburn*; chief of pediatrics, *Dr. Lorenz J. Schermerhorn*. The staff executive committee is made up of *Dr. Collisi*, *Dr. Baker*, *Dr. Southwick*, *Dr. Schermerhorn*, *Dr. Bosch* and *Dr. N. A. Wilhelm*.

\* \* \*

### **Association of Military Surgeons of the United States**

At a special meeting of the Executive Council of the Association of Military Surgeons, which was held at the Army and Navy Club, Washington, D. C., January 7, 1938, Rochester, Minnesota, and the Mayo Clinic were selected as the next meeting place for the annual gathering of the Association, the dates being October 13, 14, and 15. At this

*(Continued on page 188)*

## PROFESSIONAL ANNOUNCEMENTS

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meeting not only the regular members of the Council were present, but also Major General Charles R. Reynolds, Surgeon General of the Army; Rear Admiral P. S. Rossiter, Surgeon General of the Navy; Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service; Dr. Philip B. Matz, representing Dr. Charles M. Griffith, Medical Director of the Veterans' Administration, and other outstanding medico-military men.

\* \* \*

The "Golfers Special" to Frisco for the A.M.A. Convention, June 13 to 17, 1938, includes an ocean voyage from New York to New Orleans on the S. S. Dixie, June 1 to 7. The first game of golf will be played in New Orleans on June 7, followed by stops at Houston, Galveston, San Antonio, Los Angeles, Del Monte and finally the big A.M.G.A. tournament in San Francisco on Monday, June 13.

After four days in San Francisco, the party will return through Portland, Seattle, Vancouver, Lake Louise and Banff, with two additional games of golf.

Non-golfers as well as golfers (and their ladies) are invited

For further information and particulars write Bill Burns, 731 No. Capitol Street, Lansing.

\* \* \*

Just to remind you, a list of some of your friends who entered technical exhibits at the Grand Rapids Convention of the Michigan State Medical Society, will be published each month in THE JOURNAL.

For your convenience here are ten of the firms which displayed their products at the Michigan State Medical Society Annual Meeting in September, 1937:

H. J. Heinz Company, Pittsburgh, Pa.  
Holland-Rantos Company, Inc., New York, N. Y.  
Horlick's Malted Milk Corporation, Racine, Wis.  
The G. A. Ingram Company, Detroit, Mich.  
The Jones Surgical Supply Company, Cleveland, O.  
The Kellogg Company, Battle Creek, Mich.  
A. Kuhlman & Company, Detroit, Mich.  
Lea & Febiger, Philadelphia, Pa.  
Lederle Laboratories, Inc., New York, N. Y.  
J. B. Lippincott Company, Philadelphia, Pa.

\* \* \*

The Michigan State Medical Society is not now and never has been in favor of socialized medicine or compulsory sickness insurance. In 1934, its committee on medical economics presented a mutual health service plan to the House of Delegates of the State Society as a committee report, upon which no action has been taken.

Since 1931, the Michigan State Medical Society has sponsored studies costing \$20,168.96 designed to perfect both the distribution of medical care and its high quality. It has gone far to cut the cost of illness. From its comprehensive surveys, it finds no existing evidence of comparable data to show that a socialized medicine system would work in Michigan. This State is unique in its government, per capita wealth, type of population, rural and urban areas, etc.

\* \* \*

What is a Wassermann-fast case? A Wassermann-fast case is one that presents no clinical findings of active syphilis including negative spinal fluid or evidence of cardiovascular disease and continues to run a positive serological test on the blood serum for syphilis in spite of an amount of treatment considered adequate to arrest the average case. This amount of treatment might be defined differently by various authorities. Most authorities agree that it should consist of a minimum of twenty-four injections of arsenicals and a similar amount of heavy metal (bismuth or mercury) and be given continually without break in treatment regularity. In other words, a case might receive

this total amount of treatment but if the treatment was administered sporadically, say six injections of each, yearly, this would not be sufficient to classify the case as Wassermann-fast according to definition.

\* \* \*

*Modern Hospital* made the following editorial comment, in discussing the question of the right of a governmental hospital (such as Hurley Hospital, Flint) to limit its staff to doctors of medicine:

"Hence, the board of trustees of such an institution (government hospital) may decide what in their judgment is the safest practice to follow in the care of the sick and indigent. Even when statutes limit the free action of the boards of government hospitals in respect to the exclusion of cultists, more than one jury has protected the cause of the patient. The high standing of the hospital staff is the business of the board of trustees. It and only it may close the institutional doors to the quack and pretender.

"This is sound reasoning. Hospital standards cannot be maintained if medical staff personnel is of a low grade. Staff standards cannot be maintained if practitioners of all types and sects are granted staff membership. Hospitals cannot receive approval and Class A rating from the American Medical Association and American College of Surgeons—important ratings—if they permit others than doctors of medicine to practice in the institution. Surely, no hospital management wants to take the risks involved in opening its doors to the unqualified."

\* \* \*

#### Michigan Pathological Society

The Michigan Pathological Society held its annual meeting at the University of Michigan Hospital at Ann Arbor, Michigan, on December 12, 1937.

The scientific subject for the meeting was "Criminological Pathology." The University Hospital staff presented interesting material illustrating the pathologic lesions of severely burned bodies and technic for identification and determination of the relationship of the time of death to the time of burning. The presentation also included a demonstration of the fluorescence of various materials under ultra-violet light and the possibilities of the application of this method to an analysis of stains in fabric.

The following officers were elected for the ensuing year: President, Dr. R. C. Wanstrom; president-elect, Dr. O. W. Lohr; secretary-treasurer, Dr. W. L. Brosius; councillor, Dr. A. A. Humphrey.

\* \* \*

The *Mississippi Valley Medical Society* offers a cash prize of \$100.00, a gold medal and a certificate of award for the best unpublished essay on a subject of interest and practical value to the general practitioner of medicine. Entrants must be ethical licensed physicians, residents of the United States and graduates of approved medical schools. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society (September 28, 29, 30, 1938), the Society reserving the exclusive right to first publish the essay in its official publication—the *Radiologic Review and Mississippi Valley Medical Journal*. All contributions shall not exceed 5000 words, must be typewritten in English in manuscript form, submitted in five copies, and must be received not later than May 15, 1938. Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Ill.

\* \* \*

#### Physician Artists

The American Physicians' Art Association, a national organization of medical men who have ability in the fine arts, will hold a first national exhibition in the San Francisco Museum of Art, San Francisco, California, in June, 1938. (The American Medical Association Convention is June 13-17 in the same city). The American Physicians' Art

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Association already has an outstanding membership. There are three classifications for membership: active, associate, and contributing. The first annual exhibition promises to be of unusual interest with entries to be accepted (after jury selection) in the following classifications: oils, watercolors, sculpture, photography, pastels, etchings, crayon and pen and ink drawings (including cartoons), wood carvings and book bindings. Scientific medical art work will not be accepted. The exhibition is not limited to first showings. All entries close April 1, 1938. Any physician interested should communicate at once with the Secretary of the American Physicians' Art Association, Suite 521-536 Flood Bldg., San Francisco, California.

\* \* \*

*Dr. Daniel Herkimer and Dr. Dayton O'Donnell* of Detroit have returned from two months travel in Europe in which a portion of the time was spent in postgraduate work in Vienna. In their travel in Germany, the impression was gleaned that the people were contented and prosperous. Dr. Herkimer explains, however, that this is a superficial observation, that a longer sojourn and more intimate contact with the people might give a different view. He was impressed with the military preparations and particularly the wonderful military highways that lead across the country, usually at some distance from large cities. These highways make for speed should mobilization be suddenly attempted. Dr. Herkimer spoke of satisfactory opportunities for instruction in the English language which has been secured by the American Medical Association of Vienna. A doctor from the United States or elsewhere, however, who has a good speaking knowledge of the German language can get along in Vienna much more cheaply so far as fees are concerned, than non-German students. He also adds that the foreign student is an observer and is not permitted to perform operations.

\* \* \*

*The Crippled Children Commission*, in coöperation with the Michigan State Medical Society and the Postgraduate Department of the U. of M., sponsored a "Refresher Course," financed by Social Security funds, on December 13, 1937. The meeting was held in Sturgis at the Hotel Elliott.

Dr. John Law of the Pediatric Division of the U. of M. gave a talk on the problem child, illustrated with lantern slides; Dr. Clarence Snyder, Orthopedic Surgeon of Grand Rapids, presented information on the use of skeleton traction on fractures of the lower extremities.

They, too, were present at the refresher clinic, with physicians coming from Hillsdale, Cass, Branch and St. Joseph counties, and a number from Indiana.

The refresher clinic was followed on the next day by the Handicapped Child's Clinic, in which 182 children were registered during the day. The examining physicians included Dr. Clarence Snyder and Dr. Wm. Scott, psychiatrist, of Kalamazoo. This clinic was sponsored by the Michigan Association for Crippled Children in coöperation with the Sturgis Rotary and Exchange Clubs. Dr. David M. Kane of Sturgis was in charge of arrangements.

\* \* \*

#### Foundation Prize

The following are the rules which govern the awarding of the annual prize of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Those interested may obtain further information by addressing Dr. James R.



Bloss, Secretary, 418 Eleventh Street, Huntington, West Virginia.

(1) The award, which shall be known as "The Foundation Prize," shall consist of \$500.00.

(2) Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M.D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal Surgery.

(3) Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant.

(4) Manuscripts must be limited to 5,000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis.

(5) The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the author's choice. Unsuccessful contributions will be returned promptly to their authors.

(6) All manuscripts entered in a given year must be in the hands of the Secretary before June 1.

(7) The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation.

(8) The President of the Association shall annually appoint a Committee on Award, which, under its own regulations, shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting.

\* \* \*

#### Brief Survey on Postgraduate Medical Education

Thirty-four states, including the District of Columbia, have some form of organized graduate medical education. Other states are planning courses and only one state reports abandonment of courses for lack of interest. Twenty-five state medical societies sponsor courses; twenty-two conduct them and eighteen do both. In several state colleges, state health departments, social security administrators and various foundations have coöperated. Twenty-four of the courses given include lectures; fifteen demonstrations; twenty conduct clinics and thirteen include all three forms of instruction; some states have devoted their annual meetings to graduate medical education. The usual length of course runs one lecture weekly for five to eight consecutive weeks. Nineteen state associations use members of the medical school faculty and sixteen employ practicing physicians for their faculties. Nearly every state association conducts some form of graduate education at a central location and also has some method by which it attempts to reach all sections of the state. The majority of the courses given are for general practitioners. They are financed from the treasuries of the state medical societies; by registration fees or by financial assistance from other sources. The results of these graduate educational activities have been excellent in every state except one.

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### CREDIT IS DUE

The following members of the Michigan State Medical Society were present at the postgraduate assemblies of the Michigan State Medical Society Annual Meeting in Grand Rapids, September 27, 28, 29, 30, 1937:

Drs. Hugo Aach, Kalamazoo; Frank A. Adams, Grand Rapids; C. A. Alexander, Kalamazoo; Reuben G. Alexander, Laingsburg; Ralph V. Allen, Grand Rapids; E. B. Anderson, Iron Mountain; Chester C. Ames, Detroit; Robert J. Armstrong, Kalamazoo; A. L. Arnold, Owosso; Ralph V. August, Muskegon Heights.

Drs. Gustav A. Bachman, Grand Rapids; Carl E. Badgley, Ann Arbor; George H. Baert, Grand Rapids; Abel J. Baker, Grand Rapids; Charles H. Baker, Bay City; Milner S. Ballard, Grand Rapids; L. R. Banner, Kalamazoo; R. H. Baribeau, Battle Creek; James W. Barnebee, Kalamazoo; S. E. Barnhart, Battle Creek; Francis W. Bartholomew, Grass Lake; H. S. Bartholomew, Lansing; F. W. Baske, Flint; C. M. Baskerville, Mt. Pleasant; D. K. Barstow, St. Louis; LaMott F. Bates, Durand; Willard G. Beattie, Ferndale; O. O. Beck, Birmingham; Horace J. Beel, Grand Rapids; Carl B. Beeman, Grand Rapids; G. W. Behan, Galesburg; William C. Behen, Lansing; Charles M. Bell, Grand Rapids; C. D. Bennett, Kalamazoo; John H. Besancon, Detroit; William L. Bird, Greenville; G. C. Bishop, Almont; T. P. Bishop, Grand Rapids; H. M. Blackburn, Grand Rapids; A. F. Bliesmer, St. Joseph; D. C. Bloemendal, Zeeland; P. W. Bloxson, Grand Rapids; Frank A. Boet, Grand Rapids; Leon M. Bogart, Flint; J. E. Bolender, Grand Rapids; George L. Bond, Grand Rapids; Frank M. Boonstra, Muskegon; Leon C. Bosch, Grand Rapids; Devere R. Boyd, Muskegon; C. E. Boys, Kalamazoo; Floyd Boys, Kalamazoo; Robert M. Bradley, Flint; Park S. Bradshaw, Muskegon; C. W. Brainard, Battle Creek; H. E. Branch, Detroit; F. W. Bramigk, Detroit; Francis Brennecke, Grand Rapids; Osborne A. Brines, Detroit; Iris M. Brydges, Detroit; William Bromme, Detroit; Clark D. Brooks, Detroit; J. D. Brook, Grandville; Jas. S. Brotherhood, Grand Rapids; G. M. Brown, Bay City; Willis E. Brown, Ann Arbor; Eugene S. Browning, Grand Rapids; Jacob Bruggema, Evart; E. T. Brunson, Ganges; Kathryn M. Bryan, Manistee; M. J. Budge, Ithaca; Frank L. Bull, Sparta; Austin F. Burdick, Lansing; John S. Burleson, Grand Rapids; Willard N. Burleson, Grand Rapids; Jacob H. Burley, Port Huron; W. M. Burling, Grand Rapids; Dean C. Burns, Petoskey; Milton G. Butler, Saginaw; Wm. J. Butler, Grand Rapids; Nils Olof Byland, Battle Creek.

Drs. Wm. T. Cameron, Lansing; Don M. Campbell, Detroit; Alice Fern Campbell, Albion; John F. Cardwell, Grand Rapids; Clarence A. Carpenter, Onaway; Earl Ingram Carr, Lansing; Wm. J. Cassidy, Detroit; Harold J. Cawthorne, Benton Harbor; Hector M. Chabut, Jackson; M. S. Chambers, Flint; Louis H. Chamberlin, Grand Rapids; Wm. S. Chapin, Muskegon Heights; Arthur N. Chatel, Detroit; L. F. Chess, Reed City; L. G. Christian, Lansing; J. W. Christie, Pontiac; E. O. Cilley, Grand Rapids; Nelson H. Clark, Holland; Rudolph I. Clark, Dowagiac; Robert W. Claytor, Grand Rapids; Clifford P. Clark, Flint; Leon F. Cobb, Pontiac; M. Coburn, Coopersville; Sol. G. Cohan, Muskegon; W. C. C. Cole, Detroit; Irving E. Colef, Benton Harbor; C. M. Colignon, Muskegon; Frederick A. Collier, Ann Arbor; Ward E. Collins, Kalamazoo; Harrison S. Collisi, Grand Rapids; Walter G. Colvin, Grand Rapids; C. W. Colwell, Flint; T. H. Cooper, Port Huron; G. A. Conrad, Sault Ste. Marie; Robt. C. Conybeare, Benton Harbor; Raymond J. Cook, Lansing; Ralph G. Cook, Kalamazoo; A. J. Cortopassi, Saginaw; Joseph M. Croman, Jr., Mt. Clemens; Harold D. Crane, Grand Rapids; Charles V. Crane, Grand Rapids; Walter J. Cree, Detroit; B. A. Credille, Flint; M. Edw. Cunningham, Grand Rapids; Fred P. Currier, Grand Rapids; J. C. Curlett, Detroit; Geo. James Curry, Flint; Arthur Covell Curtis, Ann Arbor.

Drs. Ernest D'Alson, Muskegon; Ernest W. Dales, Grand Rapids; Milton A. Darling, Detroit; L. H. Darling, Lansing; David B. Davis, Grand Rapids; Guy Wm. DeBoer, Grand Rapids; T. E. DeGurse, Marine City; Isla G. DePree, Grand Rapids; Conrad DeJong, Grand Rapids; Gerald DeMaagd, Rockford; Joe DePree, Grand Rapids; Richard DeMol, Grand Rapids; T. DeYoung, Sparta; S. James DeZuker, Detroit; J. H. Dempster, Detroit; Leon DeVel, Grand Rapids; Alfred Dean, Grand Rapids; E. E. Dell, Sand Lake; Charles Dengler, Jackson; R. H. Denham, Grand Rapids; Daniel DeVries, Grand Rapids; M. M. Dewar, Grand Rapids; Bernard Dickstein, Grand Rapids; Frank Diskin, Muskegon; Willis L. Dixon, Grand Rapids; Warren M. Dodge, Jr., Battle Creek; Sam W. Donaldson, Ann Arbor; Frank Doran, Grand Rapids; Bennard J. Dowd, Kalamazoo; C. P. Doyle, Lansing; Charles R. Doyle, Lansing; W. M. Drake, Breckenridge; James C. Droste, Grand Rapids; Henry Duiker, Grand Rapids; L. S. Douken, Greenville.

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Drs. Fredk. M. Ilgenfritz, Kalamazoo; William D. Irwin, Kalamazoo; Thomas C. Irwin, Grand Rapids; J. F. Itzen, South Haven.

Drs. C. C. Jackson, Imlay City; Robert Jaenichen, Saginaw; Fred M. Jameson, Grand Rapids; W. Jaracz, Grand Rapids; Alpheus F. Jennings, Detroit; Lydia Jesperson, Battle Creek; L. J. Johnson, Ann Arbor; F. A. Johnson, Greenville; H. H. Johnson, Martin; J. H. Johnson, Hillsdale; Charles G. Johnston, Detroit; Tyrc K. Jones, Marshall.

Drs. Roland E. Kalmbach, Lansing; G. H. Kaven, Unionville; Harther N. Keim, Detroit; Lee E. Kelscy, Lakeview; Gerrit J. Kemme, Zeeland; Thos. R. Kemmer, Grand Rapids; Rockwell M. Kempton, Saginaw; Eugene L. Kendall, Grand Rapids; Chas. S. Kennedy, Detroit; Herbert K. Kent, Lansing; F. C. Kidner, Detroit; Paul B. Kilmer, Reed City; M. R. Kinde, Battle Creek; M. J. King, Detroit; F. O. Kirker, Sandusky; J. G. Kirker, Detroit; Victor F. Kling, Ionia; Emory L. Kniskern, Muskegon; P. A. Koestner, Kalamazoo; Harry Kok, Benton Harbor; H. P. Kooistra, Grand Rapids; W. C. Kools, Holland; John Kremer, Grand Rapids; A. H. Kretchmar, Flint; Norman R. Kretschmar, Ann Arbor; Henry J. Kreulen, Grand Rapids.

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The above list represents the registration of Tuesday, September 28, 1937. The registration of Wednesday and Thursday will be published in succeeding issues of the JOURNAL.

#### Dr. Rollin H. Stevens Honored

A testimonial dinner was tendered Dr. Rollin H. Stevens of Detroit, January 28, by the Grace Hospital Staff, together with the Detroit X-ray and Radium Society and the Detroit Dermatological Society. The occasion was the doctor's seventieth birthday. The January (1938) number of *Radiology*, the official publication of the Radiological Society of North America, was a Stevens number. The opening paper of *Radiology* was entitled "Rollin Howard Stevens, An Anniversary Chronicle of His Useful Life," by Dr. Percy Brown of Boston. Each guest at the dinner received a copy of this interesting paper in reprint form. Dr. Howard P. Doub of the Henry Ford Hospital staff and president of the Radiological Society of North America, presented Dr. Stevens with a leather-bound volume of the January issue of the society's journal, *Radiology*. A barometer and thermometer were presented by Dr. E. W. Hall, president of the Detroit Roentgen Ray and Radium Society, and Dr. G. Warren Hyde, vice president of the Detroit Dermatological Society, gave him a lamp. A biographical sketch of Dr. Stevens' life was given by Dr. M. A. Darling, chief of Obstetrics at Grace Hospital, who also presented to him a traveling bag from the staff of that hospital. With Dr. Stevens as guest of honor at the dinner was Dr. Mary Ella Thompson Stevens, his wife.

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**FEVER THERAPY.** Abstracts and Discussions of Papers Presented at the First International Conference on Fever Therapy. College of Physicians and Surgeons, Columbia University, New York City, March 29, 30, 31, 1937. Edited by the Members of the American Committee: Dr. Walter M. Simpson, Dayton, Ohio, Chairman; Dr. William Bierman, New York City, Secretary; Dr. Charles M. Carpenter, Rochester, New York; Dr. Charles A. Doan, Columbus, Ohio; Dr. Frank W. Hartman, Detroit, Michigan; Dr. Leland E. Hinsie, New York City; Dr. Frank H. Krusen, Rochester, Minnesota; Dr. Clarence A. Neymann, Chicago, Illinois; Dr. Stafford L. Warren, Rochester, New York. Price, \$5.00. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, New York, 1937.

**SURGICAL PATHOLOGY OF THE DISEASES OF THE NECK.** By Arthur E. Hertzler, M.D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, Professor of Surgery, University of Kansas. 206 illustrations. Philadelphia, Montreal and London: J. B. Lippincott Company, 1937.

**PRENATAL AND POSTNATAL MANAGEMENT.** By J. St. George Wilson, M.C., M.B., Hon. Obstetric and Gynecological Surgeon, Royal Infirmary, Liverpool, with a Foreword by Sir Comyns Berkely, M.C., M.A., M.D., pages 206, price \$4.00. William Wood & Company, Baltimore, 1937.

**PRACTICAL PROCTOLOGY.** By Louis A. Buie, A.B., M.D., F.A.C.S. Head of Section on Proctology, The Mayo Clinic; Professor of Proctology, The Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota. Illustrated. Philadelphia and London: W. B. Saunders Company, 1937.

This author feels that proctologic diseases have not received, heretofore, the consideration that they justly deserve. This is due in part to an inherent modesty of the patient and in part to lack of knowledge and appreciation of these symptoms by the physician when they are presented. In his chapter on the attitude of the physician and of the patient, he attempts to correct this fault. Throughout this work the author attempts to make the physician and patient conscious of the gravity of symptoms that arise from this class of disease. His descriptions are clear and concise. Many drawings enhance the value of the text. The descriptions of treatment advocated are of those used at the Mayo Clinic. For the general practitioner this work should be of great value.

**A PRACTICAL TREATISE ON DISEASES OF THE SKIN FOR THE USE OF STUDENTS AND PRACTITIONERS.** By Oliver S. Ormsby, M.D. Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. Fifth Edition, Thoroughly Revised; Illustrated with 658 Engravings and Three Colored Plates. Philadelphia: Lea and Febiger, 1937.

In this edition the author has revised and completely rewritten several chapters. There have also been included descriptions of several new skin diseases. The arrangement of the subject matter is the same as in previous editions. The descriptions are clear and detailed. The many illustrations, of which many are new, properly enhance the value of the descriptions. The chapter on external treatment is particularly interesting in its descriptions of the various drugs used and their actions in the various strengths employed. Herein one finds clarified the reason for some of the dermatologic prescriptions one finds recommended. Footnotes furnish references to many papers on dermatologic subjects, thus amplifying the text for the aid of investigative and research students.

**CLINICAL ENDOCRINOLOGY.** By Samuel A. Locwenberg, M.D., F.A.C.P., Clinical Professor of Medicine, Jefferson Medical College, Philadelphia; Asst. Visiting Physician, Jefferson Hospital, Visiting Physician, Philadelphia General Hospital, Northern Liberties Hospital and Eagleville Sanatorium for Consumptives; Consulting Physician to the Philadelphia Hospital for Contagious Diseases; Author of "Diagnostic Methods and Interpretation in Internal Medicine." Foreword by Hobart A. Reinmann, M.D., Professor of Medicine and Clinical Medicine, Jefferson Medical College, Philadelphia. 778 pages with 194 illustrations and 37 charts and tables. Philadelphia: F. A. Davis Company, 1937.

In recent years, endocrinology has made rapid strides and its contributions to the medical literature have been vast. It is indeed welcome to the student and particularly to the practitioner to have access to a source of information about the endocrine glands so arranged and brought up to date as to give him a bird's-eye view of the progress being made toward understanding and making practical application of these glands and their products. The author treats the subject in a duly cautious manner, cognizant of the debatable questions as well as of the known facts, and he has attempted to interpret involved questions giving the reasons for his opinions. Each endocrine gland is discussed thoroughly, including anatomical position, a short historic sketch, the physiology, the more important researches, the specific hormones, and the pathology of the gland. The discussion is ably supplemented by excellent illustrative photography, most of which is original with the author, who has himself dealt with a considerable number of endocrinopathies. Some valuable comprehensive charts and tables are included. One would do well to have such a volume for reference inasmuch as the material is well organized, lucidly presented, and brought up to the minute.

**THE DIGESTIVE TRACT: A Radiological Study of its Anatomy, Physiology, and Pathology.** By Alfred E. Barclay, O.B.E., M.A., M.D. (Cantab.), D.M.R.&E. (Camb.), M.R.C.P., F.A.C.R., Honorary Radiologist to the Nuffield Institute for Medical Research, Oxford. Formerly Lecturer in Medical Radiology, University of Cambridge, Hon. Medical Officer in Charge of the X-Ray Department, Manchester Royal Infirmary, and Lecturer in Clinical Radiology, University of Manchester. Sometime President, British Institute of Radiology; Electro-Therapeutic Section, Royal Society of Medicine; Roentgen Society; and Electro-Therapeutic Section, British Medical Association. Second Edition. 296 Illustrations and 427 pages. Price: \$12.00. Cambridge: The University Press. New York: Macmillan Company, 1936.

No examination of the alimentary system is complete that omits examination by the x-rays. This is generally conceded. Furthermore, such examination yields the most accurate results when made by one who spends the major portion or all of his time making x-ray examinations, whether he be roentgenologist or gastro-enterologist. It is better that the referring surgeon or internist be conversant with the methods of the roentgenologist. This will serve as the reviewer's explanation for emphasizing the importance of such a work as the present volume to those who do not include x-ray apparatus among their office equipment. "Roentgenology of the Digestive Tract" makes possible a knowledge of regional anatomy that can be obtained in no other way. The surgeon, who gets a direct view of the abdominal viscera, sees them under abnormal circumstances of local or general anesthesia; the anatomist in the dissecting room sees the abdominal organs in a very much altered state from the living. The roentgenologist with his opaque meal or opaque enema is enabled to study the living and normally functioning abdominal organs. Of Barclay's work, 180 pages are devoted to a study of normal anatomy and physiology—the mechanics of digestion. Anatomy and physiology and pathology, says the author, the



roentgenologist sees as a whole; they are not compartmentalized. It is the task of the roentgenologist to study the living functioning human being. To quote Barclay:

"It is for him to take the bare facts of descriptive anatomy and clothe them with the attributes of life; to take the observations of the physiologist and show whether the deductions from the laboratory and animal experiments are applicable to the living subject; and to interpret the changes in the normal shadows that are the result of disease. The waywardness of Nature, the entire absence of standards both in form and functions, make it impossible for medicine ever to be an exact science. What a dull business it would become if it could be reduced to formula! For many of us it would cease to have any attraction. The incalculability of the human element, the balancing of a hundred bits of insufficient, and perhaps contrary, evidence call up in us that indefinable instinct that goes by the name of clinical sense. It is this that makes medicine such a fascinating study, one in which the greatest masters are ever students, learning by experience to their last days. The radiologist must study medicine and its auxiliary branches from his own angle, and the wider his clinical knowledge, the more valuable will be his opinion." (An example of the author's style.)

This precludes the possibility of the subject ever revealing itself to the possessor of an x-ray apparatus who is not willing to pay the price in years of conscientious study.

Following the study of the normal digestive tract, the author devotes the remainder of the work to the pathology it may be heir to. Barclay alive and active, was contemporary with many of the pioneer roentgenologists who have passed away. To mention two in our own state are Hickey and Crane whose work he has acknowledged. The author's use of illustration is a feature deserving of special comment. His pictures have a purpose. Some are half-tones from roentgenographs; some are inked in from drawings based on radiographs; others are line drawings. But all, together with his lucid descriptions, make a text that is clarity itself. The work is delightful reading. The author never permits himself to become bogged in the mire of sesquipedalian verbiage that too often mars medical writing. Another notable feature is the concise inclusion of the author's technic, of interest to those who operate or supervise the operation of x-ray apparatus in the examination of the digestive tract. The appendix of the work contains important sections on such subjects as planning an x-ray department, radiation, risks of the roentgenologist, international recommendations for x-ray and radium protection. "The Digestive Tract" is the clearest and most comprehensive work on the subject we have seen. Its appeal is not only to the roentgenologist but to general practitioners and gastroenterologists to whom patients with impaired digestion go for relief.

**THE MANAGEMENT OF FRACTURES, DISLOCATIONS, AND SPRAINS.** By John Albert Key, B.S., M.D. Clinical Professor of Orthopedic Surgery, Washington University School of Medicine. Second Edition. St. Louis: The C. V. Mosby Company, 1937.

In this book the authors give a comprehensive discussion of fractures and other injuries involving the bony structure of the body. The general principle involved in treatment and the processes of repair and the complications that may accompany these injuries are discussed in the early chapters. Consideration is given to the equipment nec-

essary in this work and there are illustrations showing the various beds, splints, etc., that are to be used. There is a chapter on the general treatment of compound fractures in which the authors give in detail the general principles that they follow in the treatment of this type of injury. Finally specific fractures, their diagnosis and treatment are taken up in detail. The several methods of treating a specific fracture, including the use of skeletal traction, are given. Throughout the work there are many illustrations showing exact methods of diagnosis, of reduction and of the application of the several types of retention apparatus. Reproductions of x-rays add materially to the value in diagnosis. Anatomical considerations involved in the maintaining of fractures in position are illustrated by many drawings. The working-man's compensation laws affecting fractures and the medico-legal aspects of these cases are, also, covered.

A cub reporter, frequently reprimanded for prolixity and warned to be brief, turned in the following:

"A shocking affair occurred last night. Sir Edward Hopeless, a guest at Lady Panmore's ball, complained of feeling ill, took his hat, his coat, his departure, no notice of his friends, a taxi, a pistol from his pocket, and finally his life. Nice chap. Regrets and all that.

## AMONG OUR CONTRIBUTORS

**Dr. John T. Murphy** is a graduate of Toledo Medical College, 1906, and his specialty is radiology. He is a past president of the American Roentgen Ray Society and American College of Radiology, and is secretary of the Radiological Section of the American Medical Association.

\* \* \*

**Dr. Oliver S. Ormsby** is Clinical Professor and Chairman of the Department of Dermatology, Rush Medical College of the University of Chicago. He is also Dermatologist to the Presbyterian Hospital and a member of the American Dermatological Association. Dr. Ormsby is a corresponding member of the Section of Dermatology of the Royal Society of Medicine, London.

\* \* \*

**Dr. Louis A. Schwartz** is a graduate of the University of Michigan. He is Psychiatrist, consultation bureau of the Community Fund and Social Service Federation of Toledo, Ohio. He is on the staff of Harper Hospital, Woman's Hospital, the North End Clinic and is lecturer on Neurology, Wayne University, and lecturer on Mental Hygiene and Child Guidance, University of Michigan.

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## THE DIAGNOSTIC AND THERAPEUTIC VALUE OF THE MEDICAL SOCIAL STUDY OF CASES\*

GEORGE P. REYNOLDS, M.D.  
BOSTON, MASSACHUSETTS



A hundred years ago in the "horse and buggy days" the old-fashioned family doctor's practice was largely limited to the members of his own community. As a result he knew more or less intimately the majority of his patients. Many of them were his close friends. He attended them during their confinements and assisted nature in the delivery of their children. He cared for those children during infancy, childhood and adolescence and was a guest at their weddings. He shared their joys and sorrows and knew their ambitions and disappointments. This doctor's medical education had been largely acquired through daily association

with some older physician, in the visits from house to house, and his attitude toward illness was practical rather than scientific. His primary aim was more the health and happiness of the patient than the control or cure of disease, and the concept of prevention of disease was beyond his horizon. If judged by our modern standards, his knowledge of medicine was meagre, but he knew human nature and the personalities of the individuals with whom he was dealing and the application of this knowledge was one of his most valuable diagnostic and therapeutic assets.

Today, the young physician enters practice so imbued with the knowledge of an ever increasing number of laboratory and mechanical aids to diagnosis and treatment that he is prone to regard his patients as "cases" rather than human beings. He has had little, if any, opportunity to see his

patients in their homes, and he has not formed the habit of thinking of the relationship between their personal problems and their illnesses. Of course, modern teaching hospitals have medical social workers whose function it is to study and evaluate social aspects of medical cases, but as yet their work is not sufficiently integrated with that of the interne to make him realize that it is a vital part of medicine. Many house officers graduate from the hospital with the idea that the work of the Social Service Department is largely a charitable endeavor to better the lot of poor patients. They do not realize that the well-to-do have just as many and often more complicated social problems, and they do not appreciate that these problems frequently have a direct bearing upon the diagnosis and treatment of the patient's illness.

To attempt to diagnose or treat illness without consideration of the social elements in the patient's life is quite as unscientific and inaccurate as it would be to disregard

\*From the Thorndike Memorial Laboratory, Second and Fourth Medical Services (Harvard), Boston City Hospital, and the Department of Medicine, Harvard Medical School. Read before the seventy-second annual meeting of the Michigan State Medical Society at Grand Rapids, September, 1937.



the value of laboratory data. I make this statement after due consideration and I want to amplify it by citing two cases which illustrate just how social study may affect the diagnosis and treatment.

mitted by the mother. Further questioning of her failed to reveal any significant data. The patient had had no previous illnesses, her husband and one daughter aged six were living and well and the household consisted of these two, the patient, her mother and one servant. The mother, however, was the only one seen by the physician. Therefore,

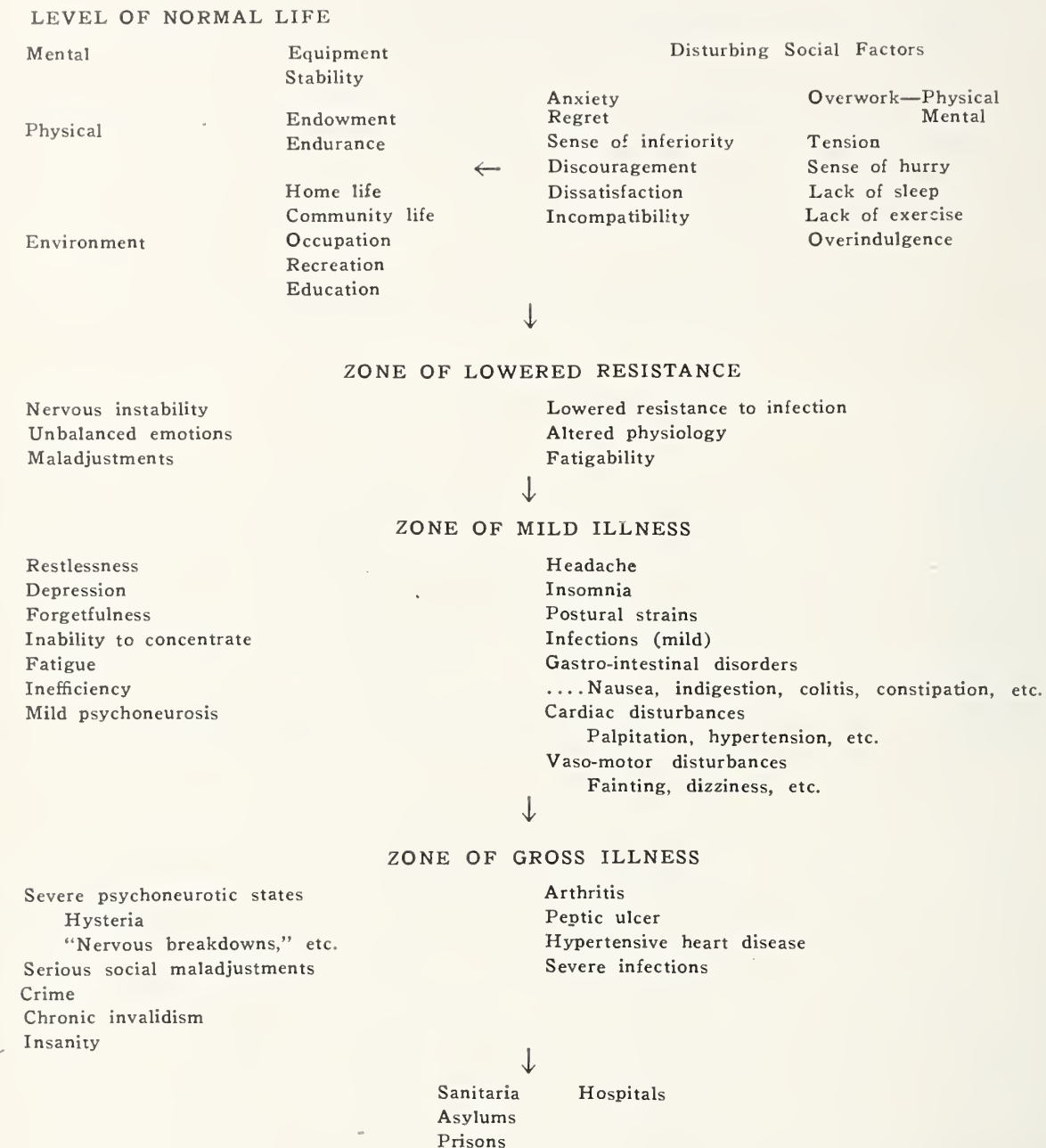


Fig. 1. Diagram showing how disturbing social factors injected into the life of a normal individual may lead to nervous or physical illness.

## Diagnosis

*Case 1.*—A physician was called one evening to see a new patient. The history as given over the telephone by the patient's mother was that her daughter had been perfectly well until after supper, when she complained of a severe headache and went to bed. An hour later the mother, on going to her daughter's room, found her lying in bed with flushed face, moaning and tossing about, but semi-stuporous and incoherent. The physician suggested immediate hospitalization, but as this was refused he went to the home, to which he was ad-

mitted by the mother. Further questioning of her failed to reveal any significant data. The patient had had no previous illnesses, her husband and one daughter aged six were living and well and the household consisted of these two, the patient, her mother and one servant. The mother, however, was the only one seen by the physician. Therefore,

Physical examination revealed a temperature of 102° F., flushed face, restlessness, semi-coma, acute pharyngitis, a suggestion of left lateral nystagmus, a stiff neck held rigidly in hyperextension, and hyperactive reflexes. The remainder of the routine examination was negative.

The physician told the patient's mother that he believed her daughter had meningitis and that a lumbar puncture was necessary to confirm the diagnosis. Just as this was to be done the patient's husband strolled nonchalantly into the room smoking a cigar. A single glance revealed the fact that

he was at least twice the patient's age and from his cold and disdainful expression it was evident that he had no great affection for his wife. As he stood by the bedside looking down at her, his hands in his pockets, his cigar in his mouth, the patient, who you will remember had appeared semi-stuporous,

## Treatment

The next case is an excellent example of the value of social study and planning to the treatment of a patient.

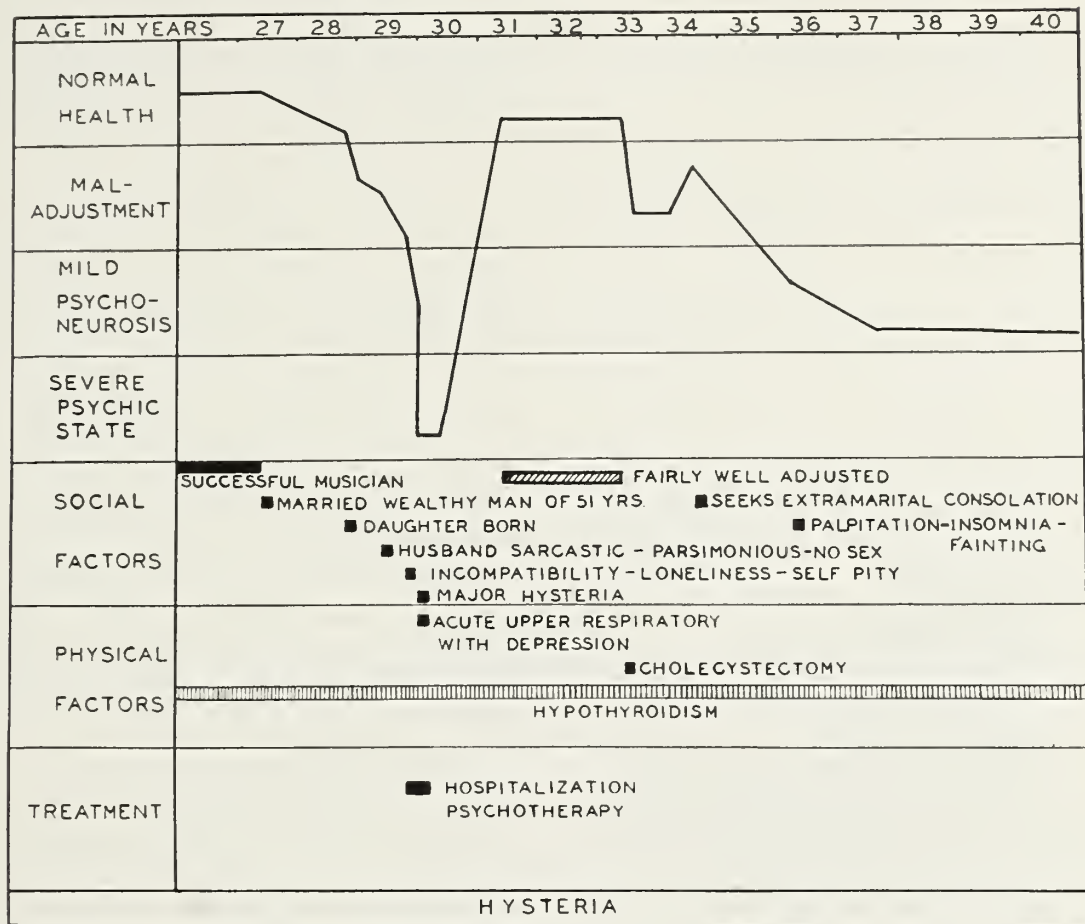


Fig. 2. Graphic representation of Case 1 in text.

opened her eyes, and, seeing him, held out her arms in a dramatic gesture of appeal. He continued to gaze scornfully down at her for a few seconds, then slowly his hand went up to his cigar and removing it from his mouth he blew a huge cloud of smoke at her and sauntered out of the room without a word. The patient burst into tears and the physician put away his lumbar puncture needle. Hysteria now seemed the most likely diagnosis and a few minutes later, when she had quieted down, the physician was able to elicit a story of extreme marital discord, mental cruelty and absence of sexual relation since the first year of marriage which confirmed the diagnosis. The fever was explained on the basis of an acute upper respiratory infection and the stiff neck and nystagmus disappeared with the emotional relief of telling her story. Had this patient been seen only in the hospital and without an opportunity to observe the husband in the patient's room the correct diagnosis would have been missed, at least until a negative lumbar puncture and the course of her illness had ruled out the possibility of a meningeal infection. Thus, the simplest form of social study, mere observation of a few minutes of domestic relations, contributed to diagnosis.

*Case 2.*—A well-to-do married woman of forty-five years was suffering from rather severe rheumatoid arthritis. The diagnosis was obvious and a careful physical examination and laboratory study revealed no complicating factors, other than rather extreme fatigue. Therefore, she was put on a regime of treatment which consisted of dietary regulation, proper bowel management, physiotherapy, bed rest at home, and appropriate medication for the relief of joint pains and insomnia. Weeks went by with no improvement in the condition of the joints nor did the patient seem to be any less tired despite the fact that she remained constantly in bed, was eating properly and sleeping well. The situation was, to say the least, discouraging both to the physician and to the patient, and finally a consultant was called. To him the outstanding feature of the situation was that fatigue had not been relieved by prolonged physical rest under what at first glance seemed to be ideal conditions, and he, therefore, directed his attention to a more thorough investigation of the minute details of her daily routine. He found nothing to criticize in her physical surroundings. She was in a comfortable bed in her own room which overlooked her garden, but which was sufficiently removed from the noises and activities of the rest of the household to be



quiet and restful. There was no evidence of lack of coöperation on the part of the patient nor of her family, and the diet was carefully supervised. A detailed history of just how the patient had passed each hour during the preceding week, however, revealed a great deal of mental activity and nervous tension. Although lying in bed, the patient had had

mittee meetings taking place in her bedroom reduced, and it was arranged that visitors and telephone calls would not reach her during certain periods set aside for complete rest. The anxiety about her two daughters was relieved by a more thorough investigation of the physical health of one and putting the other in the hands of an understanding psychiatrist who found her problem to be a simple one. Her husband read aloud to her in the evenings, which obviated the necessity of her entertaining him. Under these modifications of her regime she slowly became more relaxed and rested, her general condition steadily improved and her arthritis gradually became quiescent.

### Prevention

Now let us consider what part social study may play in the prevention of illness. One aspect is so obvious that it requires only the briefest mention. The physician's duty in the case of a patient with an infectious disease such as tuberculosis does not end with the treatment of the individual. He must make every effort to locate and examine others who may have been infected through contact with the patient. It is evident that the first step in this endeavor is to acquire an exact knowledge of the social relationships of the patient not only in his family but among others with whom he is in daily contact.

But social planning also plays an important part in other aspects of the prevention of illness. The individual who has been permanently physically handicapped as the result of some disease may be able to lead a normal useful and happy life if his activities and pursuits are so planned that they are not incompatible with his physical limitations. The adult with a damaged heart must be taught how to live as normal a life as is consistent with his cardiac restrictions. The child who has mitral stenosis should be guided in the selection of a vocation which does not entail too much physical exertion. The dangers of psychological maladjustment in a crippled child may be avoided by so planning his education that he fits himself for a position in life where that limitation is the least possible handicap. Peptic ulcer and diabetes are other diseases in which education of the patient and planning of the daily routine will aid in preventing relapses. It is easy to get the urine of the patient with diabetes sugar-free and to relieve the ulcer patient of his pain while under intensive treatment, but it is frequently difficult to keep either of them well when they return to work.

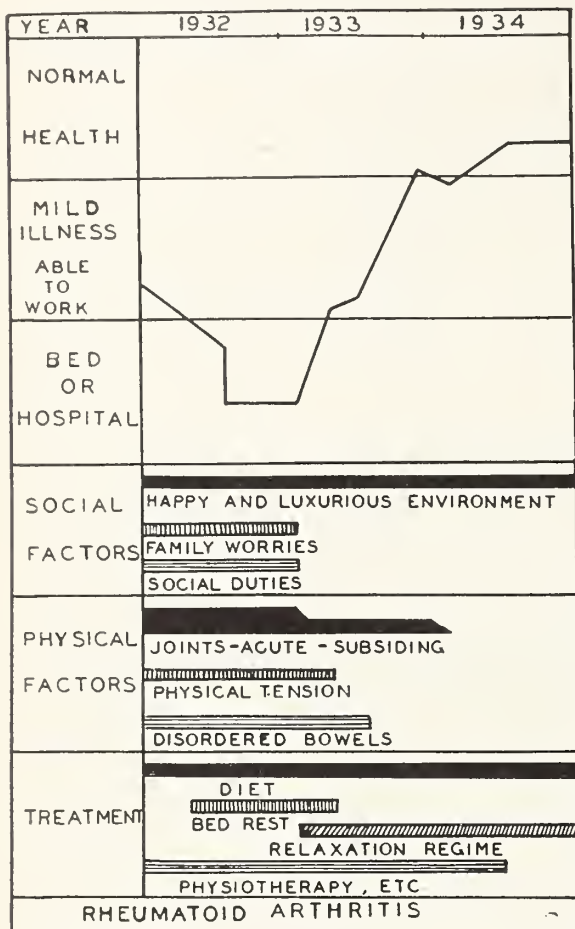


Fig. 3. Graphic representation of Case 2 in text.

many and complicated matters to deal with. There had been daily interviews with servants in regard to housekeeping, she had considered every detail of the administration of the estate and she had held many meetings of committees in relation to various charities in which she was deeply interested. She had discussed at length the problems of her elder daughter's health with a physician and had worried greatly over the general behavior and attitude of her younger daughter. And she had made a great effort each day to be cheerful and entertaining when her husband came home from business. There were many visitors, endless telephone calls and much correspondence both of a personal and business nature to be attended to each day. These activities were not to her drudgery or work, but a pleasant part of life, and she expressed herself as thankful that she was able to accomplish so much and, at the same time, "to be resting so completely all day and all night." Actually, she had had scarcely a moment in which to relax, and had therefore remained at a high degree of nervous tension and of fatigue. With proper reorganization of her life her total daily activity was greatly curtailed but not so strictly as to make her feel out of things. Most of the administrative duties were delegated to other members of the family, the number of com-

### Convalescent Care

The construction of a program for convalescent care in these two conditions, and indeed in all serious illnesses, is of vital importance. The weakest point in the treat-

extent, the care of his health. Certainly, he needs, at this time, the most careful and detailed advice that can be given. The physician should plan with him each step in the return to his normal life and should point

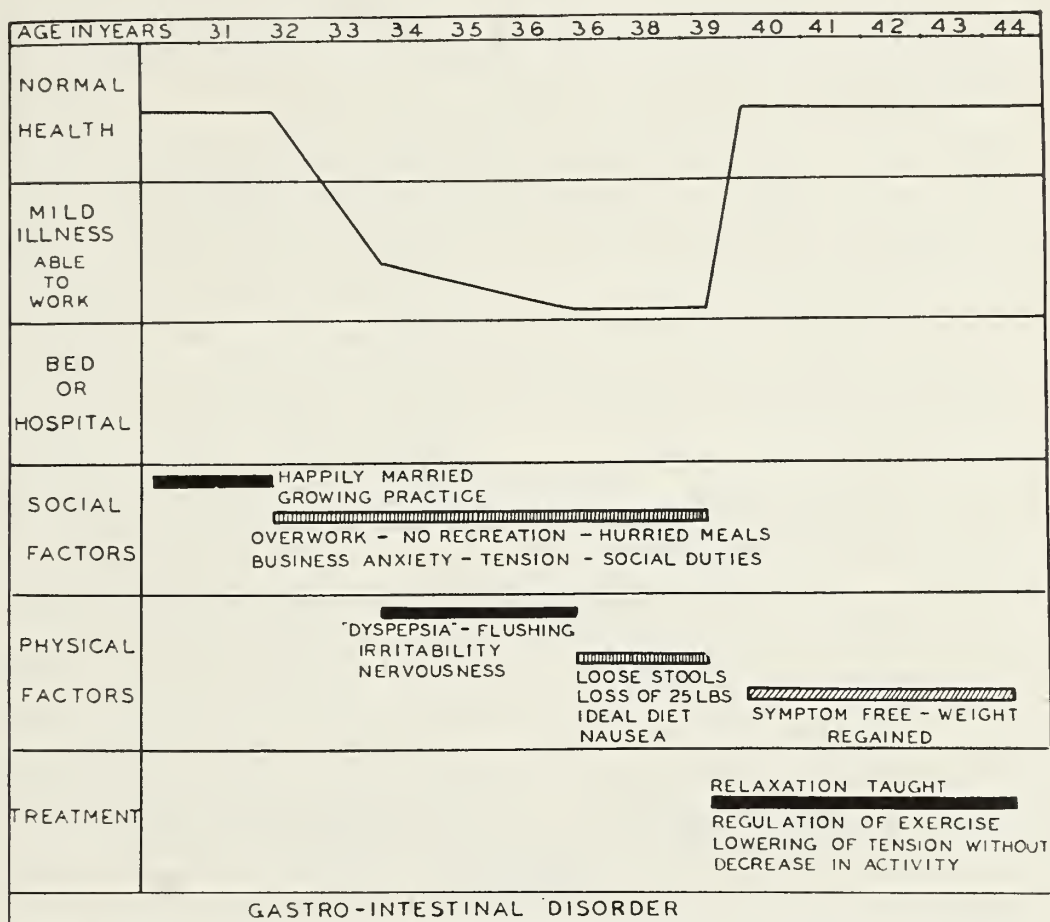


Fig. 4. Chart illustrating the relationship of social factors and physical factors to the course and treatment of a gastro-intestinal disturbance.

ment of patients today is the instructions which they receive at the time of their discharge. This is especially true in the public hospital where such advice is given usually by a comparatively inexperienced interne, but is it not also a just criticism of our attitude toward the private patient who is recuperating from an illness and to whom we are paying a few final and often hurried visits? Are we not apt to tell him to "take things easily for a few weeks more" or to give some equally vague and indefinite advice? The patient, during his illness, has turned over the management of his daily routine to his physician, and he has been encouraged to forget as far as possible his responsibilities in life. Just at the moment when he is beginning to increase his activity and to face again these responsibilities, he is expected to take over, at least to a large

out as far as possible the things to be avoided as well as the rules to be observed. The patient should not be expected to realize just what is liable to prove too much for him nor to distinguish which portions of his treatment are absolutely necessary and which merely desirable. When his normal activities conflict with the details of his convalescent regime the doctor, not the patient, should decide which is the more important. Unless this is done and the inevitable compromises between ideal and practical treatment made, the patient is liable to err too much either in one direction or the other according to his temperament. The more complete his understanding of his situation the more successful will be his management of his own convalescence.

Thus, we see that the social study is in reality an important part of the physician's



duty, a vital factor in his struggle against illness. In public hospitals the accumulation of this data has been, in large part, delegated to highly trained specialists — the social workers—who, through their experience and

service has been established for seven years and has unquestionably proved its worth. I am delighted to learn that in the State of Michigan the Committee on Health Activities of the McGregor Fund has estab-

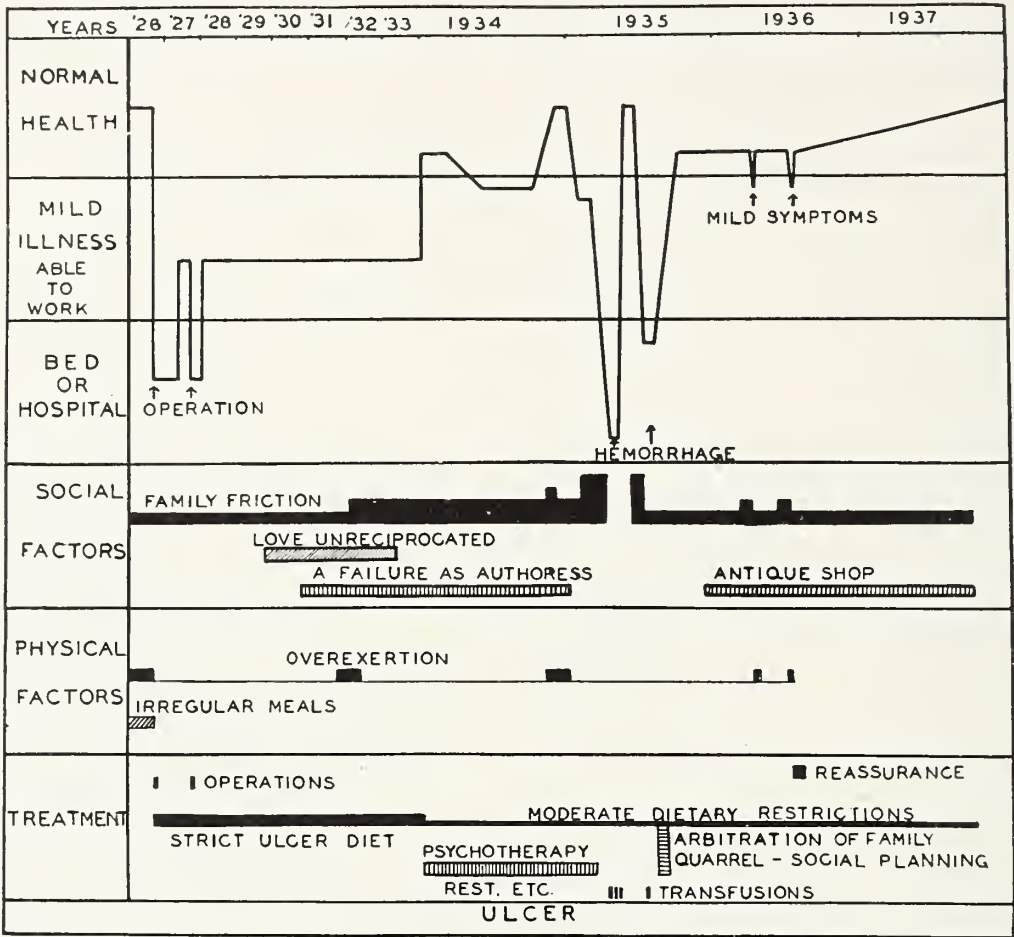


Fig. 5. Graphic representation of the apparent relationship between social planning and the relief of symptoms in a young woman with peptic ulcer.

study, have learned the best methods of acquiring the information necessary and of applying it and the resources of the community to the needs of individual patients. But, even in the public wards, the physician should supervise the investigations of the social worker and correlate her findings with the medical aspects of the patient's illness.

The physician still has to elicit and evaluate the social factors in the problems of his private patients. But the day may not be far distant when medical social service will be available to the physician in his practice. Certain steps in this direction have already been made. At the Baker Memorial Hospital, a department of the Massachusetts General Hospital devoted to the care of patients of moderate means, medical social

lished a program of medical social service for the private patients of the physicians in Detroit. This is an interesting experiment and one which should prove of great value. But I want to point out that social study and evaluation was originally a function of the physician, that, while in hospitals it has been delegated to special workers, it remains a function of the physician, and that the integration of the social factors with the medical component of the case must be done by the physician. The rôle of the medical social worker is that of a consultant in a special field who makes a certain type of examination and then offers advice, not that of a specialist who is equipped by education and experience to assume the responsibility for the care of the patient.

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## EXAMINATION OF THE CERVIX UTERI\*

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In this paper, I propose to discuss the importance of examining the cervix of the uterus under three divisions: first, as a part of a routine in pelvic examinations; second, following every obstetrical delivery; third, as a routine procedure prior to gynecological operations.

### Routine in Pelvic Examinations

It hardly seems necessary to say that a careful examination of the cervix should be a part of every pelvic examination, yet a large number of cervices, showing important pathology, escape the eye of the attending physician. Although the sense of touch is highly developed in many physicians, it cannot replace visualization of the cervix. Deep lacerations, scar tissue, retention cysts, large polypi and malignant induration when extensive can be felt, but erosions, endocervicitis, small soft polypi, and early malignancy are often missed when the cervix is not carefully inspected.

Inventive physicians and instrument makers have devised many types of lighted vaginal specula and tubular lights for illumination of the vagina, and though these instruments are useful, they are not essential. A pair of rubber gloves, the common bivalve speculum, and direct or indirect lighting are adequate equipment for thorough inspection of the cervix.

The most common lesions seen in the cervix are lacerations from labor, ectropion and erosion, endocervicitis, and polypi. Lacerations of the cervix occur in every first labor. They may be trivial, but even in normal labor there is a tendency toward rupture of the thin fibers of the cervix laterally so that varying depths of unilateral or bilateral tears are frequently seen. These will be discussed in more detail under the heading, examination of the cervix following delivery.

Injuries of the cervix lead to a prolapse or a rolling out of the normal columnar ciliated cervical epithelium so that it is exposed to the trauma, acid secretions, and infections of the vagina. The thin columnar epithelium appears as a bright red area of varying width surrounding the external os. The color is due to dilated capillaries in the connective tissue showing through this thin layer of columnar epithelium. In the pres-

ence of infection the normal squamous epithelium of the vaginal portion of the cervix becomes desquamated. Round celled infiltration occurs below the desquamated areas and ciliated cervical epithelium grows in to replace the lost squamous epithelium and to form many new cervical glands. However, as healing takes place, the squamous epithelium again invades the area covering the cervical epithelium and glands, finally healing the lesions. This metaplasia of epithelium of the cervix following laceration and infection is called ectropion and erosion.

The term "endocervicitis" is applied to infection of the glandular lining of the cervix. This is only seen in the acute stages of infection as the deeper glandular structures and tissue soon become involved, causing a cervicitis or generalized infection of the cervix. When acutely inflamed, the cervical mucous membrane becomes swollen and edematous and prolapses through the external os as a bright red surface covered with exudate. This discharge may be mucoid, or mucopurulent, or tinged with blood. In the chronic stage infiltration of the deeper supporting tissues takes place. The glands become enlarged. Their outlets are obstructed and retention cysts result. The cervix often becomes greatly enlarged. Thick, tenacious, mucopurulent cervical plugs fill the canal and cause sterility. Increased connective tissue and scars in the cervix undoubtedly cause dystocia. Not only is dilatation slow, but deep tears occur. The frequency of puerperal infections and febrile postpartum complications in multiparous women can often be traced to a lighting up of infection from a chronic cervicitis.

Physicians who constantly search for

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focal infections often fail to examine the cervix. However, this organ is ideally constructed to harbor infection and women have been cured by cleaning up infection in the cervix not only of leukorrhea, dysmenorrhea, dyspareunia, menorrhagia, metrorrhagia, but of diseases in remote parts, such as iritis. Most cases of lumbar pain in women should be treated by the orthopedic surgeon but the physician who eradicates infection from the cervix will cure a surprisingly large number of women of this ailment.

Many cervical polypi are missed when bimanual examinations of the pelvis are made without inspection of the cervix. These tumors rarely become malignant, although carcinomatous and sarcomatous changes may occur in them. When well protected in the cervix, polypi show the characteristic red color of cervical mucous membrane. The pedicle is not seen. When the tumor extends outside the external os, squamous epithelium covers its surface and it has a paler appearance. Secondary changes, inflammation, torsion of the pedicle with resulting edema, hyperemia, and gangrene are often seen in polypi.

#### **Routine Following Obstetric Delivery**

Routine inspection of the cervix immediately following delivery has been recommended by several prominent obstetricians. This, I believe, is unnecessary. Immediate inspection of the cervix, unless carried out under aseptic conditions, would add to maternal morbidity and mortality. The appearance of the cervix immediately following delivery is often startling; small lacerations appear much larger than they are; edema distorts the cervix and small interstitial hemorrhages alter the appearance of the tissues. Six to eight weeks later, the same cervix is normal in size and contour, small lacerations are well healed, the edema has disappeared, and the color of the tissues is normal. Inspection of the cervix at this time gives a true picture of the residual damage after nature has completed its reparative processes.

When circumstances require operative procedures such as manual dilation of the cervix or forceps delivery through a cervix that is not completely dilated, or when bleeding continues from a clean, tightly con-

tracted uterus, the cervix should be inspected immediately and repaired when necessary.

Involution of the puerperal cervix goes on for six to eight weeks following delivery. At the end of this time the cervix should be thoroughly inspected, for now much can be done to restore the cervix to its former condition. Glycerine tampons will dehydrate the tissues and lessen hypertrophy and edema; warm saline or boric acid douches daily will clean the cervix of exudate and hasten healing; puncture of occluded cervical glands with a small pointed cautery will care for cysts if not too numerous; the application of a larger blunt pointed cautery tip to unhealed infected ulcers and to erosions will hasten the covering of these areas with healthy squamous epithelium; when lateral tears of the cervix allow a marked eversion of cervical epithelium, deeper linear cauterizations will contract and tend to restore the former shape of the cervix, putting the cervical epithelium back into its protected position in the cervical canal. Leukorrhea, menorrhagia, metrorrhagia, and backaches are relieved by these office procedures and involution of the uterus is greatly hastened.

#### **Routine Procedure Prior to Gynecologic Operations**

Prior to pelvic surgery the cervix should always be inspected. Curtis and others have called attention to fatal peritonitis, even after minor plastic operations, due to a liberation and spread of virulent streptococci from infected cervixes. Serious infection following hysterectomy is not uncommon when the chronically infected cervix is disregarded. The present controversy between gynecologists as to the advisability of doing panhysterectomies routinely, takes into consideration the condition of the cervix. Although not proven, lacerated, scarred, infected, and eroded cervixes seem to be fertile soil for carcinomatous changes. While it is true that nulliparous women do develop carcinoma of the cervix, chronic irritation and infection probably play a part in these cases. Many gynecologists feel that by amputation of the cervix, by the Sturmdorf reconstruction operation, or by coning out the endocervical tissues, they can prevent carcinomatous changes in the cervical stump

and do a supravaginal hysterectomy with less surgical risk. It is well established that panhysterectomy is not the operation for carcinoma of the cervix.

When Schiller announced his method of painting the cervix with iodine as a routine method for detecting early carcinoma of the cervix, physicians felt that they had a valuable aid in diagnosis. The method is useful, but only as an indicator of the areas to be excised for microscopic examination. The method is simple, and is based on the fact that when Lugol's solution is painted on normal cervical epithelium the glycogen of the cells is stained a mahogany brown color, and carcinoma cells, failing to stain, appear as pearly white areas. Eroded areas show a lighter brown color. The technique of this examination is as follows:

A bivalve speculum is gently inserted into the vagina. About 10 to 15 cubic centimeters of Lugol's solution is poured in and spread over the cervix with a tampon. After a minute, the solution is removed by a tampon or wiped out gently with cotton. The unstained areas are the suspicious ones and from these should be taken the tissue for diagnosis. This tissue may prove to be early carcinoma, hyperkeratosis from prolapse, or hyperkeratosis following leucitic infection or damage to the cervical epithelium by tenacula or rough insertion of the speculum; the latter traumatic desquamations appear as narrow, sharp, and straight line scratches. This method of course is ineffective when the carcinoma begins in the cervical canal.

The earliest stage of cancer of the cervix is rarely seen. It consists of a hard nodule under an intact epithelium. These nodules can be felt before they can be seen and in these cases the Schiller method of staining is extremely useful. Most patients with carcinoma have had symptoms for three to six months before presenting themselves to the physician for examination.

As chronic endocervicitis, laceration of the cervix, cervical scars, eversion, ectropion and erosion are commonly found present with or preceding cancer, these conditions should be eradicated during the cancerous ages. To accomplish this, amputation of the cervix would seem the ideal method, but this operation should never be performed

during the childbearing period without sterilization of the patient. Fatal hemorrhage during labor is the *great danger*; and cesarean section at term is a *far safer* procedure.

The Sturmdorf plastic operation on the cervix is a very useful method of cleaning up a severe endocervicitis. This operation is not simple, but when done correctly it removes the endocervical tissues and the scarred, thickened, hypertrophied cervical tissues. In addition, it relines the cervical canal with healthy squamous epithelium from the vaginal portion of the cervix.

A simple method of treating endocervicitis is to cone out the cervical and endocervical tissue. This can be done cleanly and easily by a high frequency coning knife. The older machines for this purpose were very expensive, but inexpensive apparatus is now available. The simplicity of this method has led some physicians to do this operation as an office procedure. This, I believe, is unwise. The patient should rest at least three days in the hospital and about one week more in her home. The immediate dangers from this operation are two-fold: lighting up of a virulent infection that has been latent in the cervical tissues; secondary hemorrhage from cervical vessels that were coagulated at the time of operation. This danger of hemorrhage can be greatly lessened by ligating active bleeding vessels and coagulating small bleeding points after coning the cervix. In spite of these precautions secondary hemorrhages requiring immediate packing or suturing do occur. Beginning ten days after the operation, warm douches of boric acid or normal saline will make the patient more comfortable by clearing up the leukorrheal discharge from the denuded area. About four to six weeks after the operation the squamous epithelium from below and the columnar epithelium from above cover the cervical canal and heal the operative site. Occasionally, contraction and healing will completely close the external os and it becomes necessary to dilate the canal. This complication is found more often after extensive removal of tissue in hypertrophied and deeply lacerated cervixes. It seems unnecessary to say that all tissue removed from the cervix by biopsy or operative methods should be saved and sent to the pathologist. Only by this means will



early carcinoma be diagnosed and our percentage of cures be increased.

### Summary

Inspection of the cervix should be made a part of every pelvic examination. Six to eight weeks after confinement the cervix should be examined and the needed office treatment given. Prior to a decision concerning gynecological operation, whether by

the abdominal or the vaginal route, a careful inspection of the cervix will aid greatly in arriving at a wise decision and do much to conserve the health and life of the patient. If patients with carcinoma of the cervix are to be cured, every physician must be on the alert to detect changes in the cervix and to know by pathological examination the true condition of the tissues of this organ.

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## STRABISMUS\*

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Strabismus is one of the most common eye conditions seen by the physician in the general practice of medicine, yet it is often one of the least understood as to its etiology and treatment. Our understanding of its development and treatment has changed so markedly during the past ten years that there is still too much diversity of opinion even among eye specialists to inspire confidence and coöperation in the prescribed methods for correcting the deformity.

The popular conception among laymen of the causes of strabismus are commonly accepted by the physician in order to avoid argument and the necessary time required to inform the mother that it was not the whooping cough that caused the child's eye to turn but rather other inherent deficiencies in the development of her child. It is very convenient to attribute our children's physical or mental handicaps to some unavoidable injury or sickness, rather than to some abnormal germ plasm in ourselves. However, no single theory will today explain all types of strabismus and it is quite likely that there are usually several factors combining in any given case to result in the deformity. Briefly, the following factors are considered to be productive of strabismus: (a) Hereditary influences. These are commonly overlooked by the physician and laymen alike even though other members of the same family are similarly affected. (b) Defective fusion. At birth the child's eyes are not perfectly coördinated in their movements and such coördination does not take place for six to eight weeks. This faculty of working together is termed fusion and permits the individual to superimpose the images seen by the two eyes into one composite picture, which in its higher degrees

of development gives us the depth perception enjoyed by most of us. This fusion sense may be congenitally absent, in which case it cannot be developed by any therapeutic measure. It is impossible to select those with congenitally absent fusion from those with poorly developed fusion until treatment has been tried. Those children having strabismus from birth or soon after birth usually have a congenital absence of the fusion sense. The majority of squinters have a poor development of the fusion sense at birth and show little tendency without appropriate treatment, to improve this function during the first six years of life as normal children do. (c) Refractive Errors. The lack of development of the fusion center in itself would not be likely to produce strabismus but when combined with refractive errors of high degree, strabismus is a likely result. In most instances of strabismus the vision is better in one eye than the other due to a higher degree of farsightedness or astigmatism. The child soon learns to ignore or suppress the blurred image and to fix with the better eye. (d) Abnormal Extra-ocular Muscle Balance. If there is a faulty fusion together with an abnormal extra-ocular muscle balance, the weaker eye will tend to deviate.

\*From the Department of Ophthalmology, University of Michigan, Ann Arbor, Mich. Read before the General Session of the Michigan State Medical Society, September 30, 1937.

As a result of the deviation of the poor eye and its non-use, the central vision of the deviating eye becomes less and less acute so that amblyopia is produced.

There is a second form of strabismus, not due to the above causes but due to congenital or acquired paresis or paralysis of one or more extra-ocular muscles. Such cases are more easily understood and their therapy is entirely surgical in nature. Quite commonly, however, a paresis of one or more of the vertically acting muscles accompanies a non-paralytic horizontal squint. In such cases the paralytic portion of the deformity should be corrected surgically early in life so that the treatment of the non-paralytic horizontal squint may progress. Complete cures are less easily obtained in this group because of our inability to entirely overcome in all fields of fixation the variable displacement of the visual axes caused by the paralytic muscle.

As a result of the presence of strabismus in a child, there are certain important factors to be considered and prevented if possible. First, the cosmetic defect itself is a handicap in later life where personal appearance plays such an important part in one's success. Second, to be considered is the possible loss of useful vision in the squinting eye, thus making the child a one eyed individual throughout life thereby barring him from many occupations where binocular vision or useful vision in each eye is required. The fact that only one useful eye remains increases the hazards of ordinary life should the fixing eye become injured. The third consideration is that of the psychological influence which the crossed eye might have on the personality of the child. Permanent personality changes are very commonly seen and unless the condition is corrected before school age, the child is likely to become sensitive, shy, introspective and retiring in nature. The early recognition on the part of the physician regularly attending the child will in a large measure prevent this sequence of harmful events from occurring.

By a proper understanding of strabismus and its effects on the child, the interested family physician will direct the child into the hands of one specially trained in eye disorders, since the technical steps necessary for a complete cure are best carried out by him. Unfortunately we still find doctors advising parents of strabismic children that

nothing need be done, that the child should be given a chance to outgrow their defect. That this advice is ninety-nine per cent incorrect is borne out by clinical experience. With a proper insight into the treatment of strabismus, the following steps should be carried out from the time the squint is first discovered.

At the first appearance of the strabismus, an ophthalmologist should be consulted since delay may cause valuable time to be lost and thus prevent the most rapid and complete cure. The longer the squinting habit persists, the more difficult it is to re-establish normal use of the eyes together. The first consideration of the ophthalmologist is the testing of the eyes under atropine to determine if there is need of correction in one or both eyes such as will influence the squint. Depending on the age of the child, from three to six months of constantly wearing needed glasses will indicate whether or not glasses will improve the squint by improving the vision and lessening over-accommodation. Along with the wearing of proper glasses, or if the child is seen earlier than one year of age before glasses can be prescribed, one per cent atropine should be instilled in the fixing eye once daily, or if atropinization of the fixing eye does not cause the child to shift fixation to the squinting eye, the fixing eye should be completely and constantly occluded by a patch in an attempt to improve the vision in the squinting eye. This is a very important step in that amblyopia develops in the deviating eye in a very few months. Our best results are obtained early in life and seldom are results obtained after six years of age. Atropinization or occlusion is not necessary in those possessing an alternating strabismus in that in these individuals the vision is always good in both eyes and amblyopia is not feared. Unless this prevention of lowered vision in the squinting eye is accomplished, a complete cure resulting in straight eyes having binocular vision and depth perception cannot be attained. By starting our treatment before six years and preferably before three years of age we now know that a good percentage of our amblyopic eyes can be trained to useful vision thus aiding us in later obtaining complete cures of the squint when the eyes are made parallel.

The fourth step in the complete cure of the strabismic child is the awaking of the



fusion sense or the ability to use the two eyes together after they have become straight. This treatment is carried out either before or after the eyes have been operated upon depending upon whether operation was necessary to make the eyes parallel. In the lower grades of squint, operations may be avoided if a high degree of fusion can be developed thus holding the eyes parallel. Fortunately fusion is sometimes easily developed and perfect cures are then possible providing all treatment is given before the end of the sixth year. Unfortunately, however, by far the majority of our squinting patients have been given glasses only and have not been in the hands of those interested in conducting the whole sequence of treatment through to a cure until after their seventh year of life when hope for a cure is lost. This problem of developing fusion so that the two eyes are restored to their normal functions is known as orthoptic training. On the whole this is a difficult form of treatment in that it usually requires the services of a specially trained technician who has plenty of patience and resourcefulness to hold the child's interest in these exercises over several months time. It is often difficult to obtain the parents' coöperation for this training in that they are not able to observe the improvement obtained and unless the squint is showing improvement they soon lose interest. Where the training can be carried out intensely in selected children under seven years of age brilliant results are often obtained. Unfortunately, orthoptic training lends itself admirably to the purposes of unscrupulous physicians and pseudo-medical specialists so that its proper place in the treatment of strabismus is clouded by many unfavorable impressions. When properly and intelligently used, orthoptic training is an important part of the treatment of strabismus. The average ophthalmologist is not equipped to carry out this form of treatment so that only a relatively few individuals have access to it. I am firmly of the opinion, however, that if the other forms of treatment are used when indicated as outline, that our treatment of strabismus would show results far superior to that ever obtained before.

Those children showing a squint of around fifteen degrees are often cured by the non-surgical methods. Those of greater

degree usually require operative procedures on the eye muscles due to the presence of varying degrees of extra-ocular muscle imbalance. The correction of the muscle imbalance, thereby bringing the eyes into parallelism, facilitates the development of the fusion faculty. Once fusion is well established, the eyes will remain straight.

Most of us were taught in medical school that no surgery for strabismus should be attempted until the child was over twelve years of age. We now know that this teaching was inadequate and that there is more to the treatment of strabismus than the prescribing of glasses and later in life operating for residual crossing. Too many of these individuals had personality changes, a loss of useful vision in one eye throughout life, or an inability to attain binocular vision. By the former method of treatment, most children received the maximum correction of their squint within the first six months after wearing their glasses. Seldom was any attempt made to prevent amblyopia from developing. The parents were usually instructed that there was nothing further to be done aside from yearly refractions until after the age of twelve, when surgical straightening might be indicated. It was during this period of waiting for some miracle to happen to cause the eyes to become straight by inadequate non-surgical means that the greatest permanent damage was done.

By operating as early in life as it is found that the maximum correction has been obtained by the wearing of glasses, much improvement in our results is noted. We have found that less surgery is required to correct a given amount of crossing. By getting the eyes parallel before the age of six, fusion can often be developed, thus guaranteeing that the eyes will remain straight. There is little or no tendency for personality changes when the eyes are parallel before school age. Amblyopia prevention is carried on throughout the period of observation where improvement is obtained by occlusion of the fixing eye.

It is my feeling that operations should be undertaken as soon after the third year of life as possible and followed by systematic training to prevent amblyopia and to stimulate the development of fusion where practicable. Since the majority of our squinting cases do not present themselves

until after seven years of age, our corrections of necessity are usually surgical in nature and result only in a cosmetic correction of the deformity. The oculist will not be able to do the greatest service for his squinting patients until the public at large has been trained to present children for treatment at the first appearance of the strabismus.

In conclusion, we must admit that:

1. Our inability to prevent the development of strabismus is due to the multiplicity of factors which may combine to produce it.

2. There is no proof that illness and injury produce strabismus but that they are incidental to its occurrence.

3. A child developing strabismus should receive intensive treatment from its incipency and the technical steps in this treatment are best carried out by the ophthalmologist.

4. The surgical correction of squint as carried out by present day methods is a safe and rational procedure and is only one phase of the treatment needed.

5. Only one per cent of squinting children develop straight eyes without treatment.

6. A child whose eyes are not straight by seven years of age is a neglected child.

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## AN ANALYSIS OF THE CONTRIBUTION MADE BY PNEUMENCEPHALOGRAPHY TO NEUROLOGICAL DIAGNOSIS

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This critical study of the data obtained by pneumencephalography as carried out at the Neurological Institute of New York was prompted by the request of the American Neurological Association to estimate the contribution made to neurological diagnosis by the use of air in the investigation of neurologic conditions. The results are formulated in response to several specific questions: (1) what was the proportion of cases suffering from organic neurologic conditions subjected to pneumencephalography; (2) in what conditions other than brain tumor were air studies employed; (3) in how many cases was the clinical study corroborated by air studies; (4) in how many cases was the clinical diagnosis proved incorrect by air studies; and (5) in how many cases was an incorrect contribution made to the diagnosis by the air studies.

To obtain this information the records of 500 consecutive patients suffering from organic neurologic disorders admitted up to April, 1936, were investigated. Patients suffering from psychoses, psychoneuroses, behaviour disorders and organic non-neurologic conditions were excluded from this series of cases.

It was found that 127, representing 25.4 per cent, of these 500 cases had either an encephalography or a ventriculography during their stay in the Institute. The number of patients investigated by encephalography was 116, representing 23.2 per cent of the entire group of 500 organic cases admitted consecutively to the hospital. Seven patients, or 1.4 per cent, of the entire group, were studied by means of ventriculography.

Both encephalography and ventriculography were performed in four patients, or 0.8 per cent of the whole series.

The group of 127 patients investigated by pneumencephalography includes twenty-three definitely found to be suffering from intracranial neoplasms. The remaining group of 104 patients includes twenty-one cases in which no absolutely final diagnosis has been reached up to the present time. Certain of these patients are neoplasm suspects and it is quite possible that a number of these patients may subsequently develop expanding lesions. A considerable number represent situations which were considered suggestive of the presence of intracranial neoplasm and pneumencephalography was carried out in order to exclude as fully as possible this suspicion. Following the practical exclusion of this possibility the final diagnosis was made. The diagnostic distribution of patients investigated by pneumencephalography is as shown in Table I.



TABLE I (A). DISTRIBUTION OF CASES INVESTIGATED BY ENCEPHALOGRAPHY

No. of Cases	Final Diagnosis
29	Idiopathic Convulsive State
18	Post-traumatic Encephalopathy
16	Brain Tumor
6	Birth Injury to Brain
3	Post-infectious Encephalopathy
3	Porencephaly
2	Idiopathic Focal Motor Cortical Seizures
2	Chronic Encephalopathy of Unknown Etiology
2	Cerebrospinal Syphilis
2	Cicatrix in Brain
2	Hypoplasia: (One of cerebrum; one of cerebellum)
2	Multiple Sclerosis
1	Agenesis of Corpus Callosum
1	Retrobular Neuritis
1	Idiopathic Ophthalmoplegic Migraine
1	Rupture of Congenital Intracranial Aneurysm
1	Hereditary Sclerosis
1	Venous Angioma
1	Aneurysmal Varix
1	Chronic Adhesive Arachnoiditis
1	Polycythemia Vera with Disseminated Choroiditis
1	Huntington's Chorea
19	Diagnosis Deferred (Organic Neurologic)
116	Total

TABLE I (B). DISTRIBUTION OF CASES INVESTIGATED BY VENTRICULOGRAPHY

No. of Cases	Final Diagnosis
1	Left Parieto-Occipital Glioma; operated, verified
1	Bilateral Frontal Glioblastoma multiforme; verified at autopsy
1	Left Frontal Glioblastoma multiforme; operated; verified
1	Cerebellar Medulloblastoma; operated, verified
1	Brain Tumor Suspect; unoperated, unverified
2	Diagnosis Deferred (Organic Neurologic)
7	Total

TABLE I (C). DISTRIBUTION OF CASES INVESTIGATED BY VENTRICULOGRAPHY AND ENCEPHALOGRAPHY

1	Serous Meningitis
1	Agenesis of Corpus Callosum
1	Brain Tumor Suspect; Right Frontal; unoperated; unverified
1	Brain Tumor Suspect; operated; unverified
4	Total

In considering the question of correctness of the clinical study prior to pneumencephalography, it was found that in eighty-four cases, or 66.1 per cent of the group of 127 patients, the preliminary diagnosis was the same as the final diagnosis (Table II). In the 127 cases the clinical diagnosis was spe-

TABLE II. CASES WHERE THE PRELIMINARY AND FINAL DIAGNOSES WERE IDENTICAL

No. of Cases	Final Diagnosis
26	Idiopathic Convulsive State
17	Brain Tumor Suspects
14	Post-traumatic Encephalopathy
6	Birth Injury to Brain
3	Post-infectious Encephalopathy
2	Multiple Sclerosis
2	Cerebro-spinal Syphilis
1	Huntington's Chorea
1	Polycythemia Vera with Disseminated Choroiditis
1	Hereditary Sclerosis
1	Brain Tumor Suspect or Multiple Sclerosis
1	Rupture of Left Middle Cerebral Congenital Aneurysm
1	Pituitary Adenoma
1	Idiopathic Ophthalmoplegic Migraine
7	Diagnosis Deferred (Organic Neurologic)
84	Total

cifically corroborated by air studies in 70 cases, or 55 per cent, while in 14 cases pneumencephalography did not contribute in one way or the other.

In this group of 127 cases there were found twenty-nine, or 22.8 per cent, in which the clinical diagnosis seemed to have been proven incorrect by air studies, and these records were therefore scrutinized in greater detail. In seventeen of these twenty-nine cases the preliminary diagnosis had included the possibility, a bare possibility in many cases, that a neoplasm might be present and that its possible presence should be ruled out. In many instances this diagnosis was included merely as a suspicion, but not as a real diagnostic possibility. These seventeen air studies were reported to be normal or showed some degree of cerebral atrophy. In four cases, additional information was obtained by the air studies, but in these cases the data was informative and of interest only since it was not related in any way to the clinical diagnosis. In two cases the data obtained both clinically and by encephalography was insufficient to determine the correctness or incorrectness of the air studies.

In the remaining six cases the clinical diagnosis was found definitely to be incorrect. In one instance (No. 26794) the flat plates of the skull were first reported to indicate the presence of a meningioma and a clinical diagnosis of a meningioma was made. An encephalogram was performed and reported to be normal, thus disproving

the clinical diagnosis of a meningioma. The flat plates were therefore reviewed and the original roentgenologic error in the interpretation of the flat plates which misinformed the clinician was discovered. In the second case (No. 25618) a clinical diagnosis of idiopathic convulsive state was made, but the encephalogram showed a cicatrix of the brain. The clinical diagnosis in the third case (No. 27117) was "hydrocephalus" but the encephalogram showed no enlargement or distortion of the ventricular system. The fourth case (No. 26728) was that of an eighteen-year-old boy who presented a four-year history of tonic spasms of the right side of the body. These were always preceded by an aura consisting of a tightening of the muscles of the right arm and leg. Following this the patient would feel the toes of the right foot straighten out, the foot evert and the heel rise from the floor. There would also be slight flexion of the right arm at the elbow. These attacks lasted about ten seconds, during which he did not lose consciousness but was unable to speak. The neurological examination was negative except for bilateral nystagmoid jerks. Mentally the patient appeared to be normal. A diagnosis of neoplasm in the midbrain was made, but the encephalogram revealed normal ventricular and cisternal systems. While a definite final diagnosis cannot be made at the present writing, it was felt in retrospect that there originally was insufficient clinical evidence to justify the diagnosis of a mesencephalic neoplasm, and that encephalography had corrected an unwarranted clinical diagnosis.

The fifth case (No. 27144) was that of a twenty-three year old day laborer with a complaint of convulsions initiated by clonic movements on the right side. The first attack occurred when he was thirteen years old. When he was twenty years of age, left occipital headache made its appearance. He complained of tinnitus for the last year and dyesthesia of the right upper and lower extremities for the past six months. The right abdominal reflexes were diminished. This was the only positive evidence obtained by neurological examination. A clinical diagnosis of a left infiltrating parasagittal neoplasm of the brain was made, but the encephalogram was normal. The final diagnosis was that of idiopathic focal motor cortical seizures. It may be pertinent

in this case also to question the justifiability of such a clinical diagnosis upon such limited evidence.

The sixth patient (No. 27033) was a forty-three-year old housewife with a history of mental changes following pregnancy which occurred two and one-half years before her admission. She later developed a tremor of the right hand, a tendency to trip and fall, blurring of vision, tinnitus, headaches, vomiting and a left hemiparesis. On examination she presented a left hemiparesis with hyperactive deep reflexes, diminished abdominal reflexes and a positive Babinski sign on the left side. Examination of the fundi revealed a marked papilledema with hemorrhages and exudate. There was a suggestive right mimetic facial weakness but it was so questionable that one examiner even placed it on the opposite side. The patient was euphoric and disoriented. A clinical diagnosis of a right frontal neoplasm was made. A ventriculography was performed and the films unequivocally reversed the localization and revealed the evidence of the presence of a left parieto-occipital neoplasm. The patient was operated upon and the presence of a left parieto-occipital glioma was verified. It is interesting to note that five examiners confirmed the clinical localization of this neoplasm on the right side, all of them being deceived by false localizing evidence. The clinical picture was so convincing that no conflicting diagnoses were made.

In determining the number of times that an incorrect contribution had been made to the diagnosis by air study, it was found that this occurred in one instance, representing 0.7 per cent of the 127 cases. However, in reviewing this case thoroughly and in retrospect, it was found that the error was the result of an incorrect interpretation of the actual significance of the air shadows as seen in the ventriculogram rather than being due to misleading information provided by the air study per se. This was a case (No. 25761) of a sixteen-months-old boy who had been born by version and extraction and was well till the age of fifteen months, when he developed a left internal strabismus. This was followed by irritability, drowsiness and vomiting. He lost his appetite, voided frequently and was no longer able to sit up. It was thought that his head had grown larger. Examination show-



ed a drowsy child with a large head and a positive MacEwen sign. He had bilateral papilledema, slight internal strabismus and horizontal nystagmus. The left pupil was larger than the right. There was spasticity of the left arm while the left knee-jerk was increased as compared with that of the right side. Bilateral ankle clonus and Babinski signs were present. Flat plates of the skull showed evidence of increased intracranial pressure. A clinical diagnosis of medulloblastoma of the cerebellum was made. The ventriculogram was then reported as follows: "Marked hydrocephalus. The complete lack of air in the third ventricle except for the vicinity of the foramen of Monro makes it seem likely that there is a lesion occupying most of the third ventricle." The patient died and an autopsy reported: (1) "Medulloblastoma of the cerebellum extending into the subarachnoid space"; (2) "Internal hydrocephalus—secondary." The roentgenograms of this case were reviewed in connection with this study and in retrospect, as stated above, the error in localization was found to be due to an incorrect interpretation of the air shadows, inasmuch as subsequent study showed that the outline of a dilated third ventricle could be seen. The failure to recognize this dilated third ventricle caused the reviewer to predicate a third ventricle lesion rather than a subtentorial neoplasm causing a uniform

dilatation of the entire supratentorial ventricular system, thus contributing to a serious diagnostic error.

In the remaining thirteen cases of the 127 which were investigated by air studies, the information provided by this means of examination was either not relative to the final diagnosis or the evidence was insufficient to provide a definite diagnosis.

### Summary

It is found that air studies were done in 25.4 per cent of all organic neurologic cases in this hospital, using 500 consecutive admissions as a cross-section.

Of the 127 air injections reviewed in this study, twenty-three, or 18.1 per cent, were performed on patients found to have brain tumor, while 104, or 81.9 per cent, were performed on patients apparently suffering from some other organic neurologic disease.

In seventy cases, representing 55 per cent of the 127 patients investigated by pneumencephalography, the clinical study was corroborated by air studies.

In six cases, representing 4.7 per cent of the 127 air injections, the clinical diagnosis was proved incorrect by the air studies.

In one case, representing 0.7 per cent of the 127 air injections, an incorrect contribution to the diagnosis was made by the air studies.

## PROBLEMS IN VENEREAL DISEASE CONTROL\*

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The term, venereal disease control, is being used in this title rather than syphilis control because emphasis should be placed in the current campaign on the control of gonorrhea, as well as syphilis. Little emphasis has been placed on gonorrhea because we lacked an effective means of rapidly controlling infectiousness. Our experiences with sulfanilamide at the Social Hygiene Clinic in Detroit would lead us to believe that in it we have a drug for the treatment of gonorrhea that will closely parallel the effectiveness of salvarsan in syphilis. We realize that we may be too optimistic and that possible late toxic effects may dampen our enthusiasm. But, with such a weapon in our hands, gonorrhea need no longer be considered such a hopeless problem from a preventive medicine standpoint.

Your Advisory Committee on Syphilis

\*Read before the seventy-second annual meeting of the Michigan State Medical Society in Grand Rapids, September, 1937.

Control of the Michigan State Medical Society has outlined a plan of attack combining the services of our health departments and medical profession. You are probably acquainted with this plan. The high points are: the request that the family physician be given an opportunity to carry out the treatment with some compensation for in-

digent patients; that the State Health Department supply the drugs, laboratory facilities, active follow-up of sources, contacts and lapsed treatment cases; and finally full-time consultants in needed areas. The only thing needed, and unfortunately, it is the all-important one, is the necessary funds to put this plan into execution.

The public has shown an interest and avidity for information that is surprising. The spirit of taboo surrounding venereal disease has been broken down. Syphilis is news. Any thinking person must admit that venereal diseases are an outstanding public health problem. The supposed spirit of taboo has been used as an excuse for neglecting this important phase of public health work. Even, with the stage set, little has been done to crystallize public opinion into an overwhelming demand upon our legislators that something be done about it. It cannot be cost, since the public gladly supports our laudable tuberculosis campaign. Yet, it costs probably twenty-five times as much to treat a case of tuberculosis as one of venereal disease. Furthermore, aside from our desire to prevent needless suffering, it can be shown readily that the cost of an effective campaign for venereal disease control will be returned many times in reduction of loss of time through invalidism and taxes for institutional care. If the present control program fails, the fault can only fall on the shoulders of our profession and our boards of health, through lack of interest and failure to capitalize on this opportunity.

Our State Legislature has appropriated \$50,000 for syphilis control, as a result of the publicity already given this program. \$25,000 of this amount is to be used for laboratory and other expenses incident to the prenuptial physical examination law. \$5,000 has been returned to the State Treasury, as a result of the Governor's request for general budget reductions. This leaves \$20,000, which the State Health Department plans to use toward supplying free anti-syphilitic drugs for indigent patients. This money is so recently available that detailed plans have not been formulated as to how it will be spent. Unfortunately, no national funds are seemingly available for venereal disease control, at least, in Michigan. The public generally believes that both national and state funds have been

available and are surprised to learn that the program has had, up to the present, little more than moral support. This \$45,000 will help. No one knows how far the \$20,000 will go toward meeting the demand for drugs, when limited to supposedly indigent patients. It has been suggested that free drugs be withheld from clinics already treating indigent patients, that have a budget for this purpose, to make the supply spread farther. It is questionable whether such distinction can be made, at least without the consent of the organizations concerned. Undoubtedly, some physicians' statements of indigency will, at times, be quite elastic. This problem can only be solved by having sufficient funds to supply drugs, where requested, for all cases of syphilis under treatment. One hundred thousand dollars would be a minimum working budget, permitting more leeway in supplying drugs and at least, a skeleton Division of Venereal Disease Control, under our State Health Department. \$250,000, to set up a complete division with consultants and trained investigators for follow-up work, would be desired. Spend \$500,000 to \$1,000,000, which would be necessary, if a completely effective plan including payment of physicians for care of indigent cases, for a period of 10 years, and we, in Michigan, would be able to match the reduction in Scandinavian countries. This is only a fraction of the money we spend yearly for tuberculosis control. We have 12 times as many cases of venereal disease as of tuberculosis. The total mortality and crippling effects are higher. With our available specific drugs, venereal diseases can be much more effectively controlled. The question reduces itself simply to this—Are we willing to spend the money? It is our duty to bring these facts forcefully to the public and the funds will be available.

I am not qualified to outline a program or speak of the problems incident to lay education. It would, however, seem to me that efforts along this line have lacked a unity of purpose and sequence in presentation. Publicity should be largely under the guidance of our State Department of Health with our medical societies and lay organizations coöperating. The plan recommended by Indiana sounds commendable. They propose a committee consisting of a member appointed by each local medical society



and all health officers to be known as the "State-wide Committee." They propose sub-committees to function in communities where they exist, consisting of representatives from hospitals, nursing associations, social service workers, community fund, better-business bureau and lay organizations of all types. The larger each committee becomes, the greater its sales ability. The sub-committee should carry out the plans advocated by the State-wide Committee.

We still have much work to do in preparing our physicians with first-hand outlines of the principles of modern treatment and selling them on the idea of following such outlines. If the campaign is to succeed, especially with our aim of placing active treatment in the hands of the family physician, teamwork must prevail. Public health workers are skeptical that such a plan can work. It is up to the physicians of Michigan to prove that they can fit effectively into a program of public health control. It will be necessary to give up our individualistic leanings and willingly follow, in the interests of unity, at least, the principles of a prescribed system of diagnosis and treatment. Any successful campaign must have such a basic unity of aims and guidance. Personally, I fear this stumbling block much more than the often expressed one of inadequacy of the average physician. Not all physicians are interested in the treatment of venereal diseases. Those that accept such cases for treatment either are, or should be, fairly proficient or anxious to avail themselves of such condensed information, as we can supply. Our state and county medical societies, the postgraduate courses of the University of Michigan, the Joint Committee on Health Education, the Michigan State Health Department, et cetera, have and will continue to make such information available.

One pressing problem for which I have heard no solution, with the possible exception of the medical coördinator plan of personal contact used in Detroit, is how to reach the "back-slider" in our ranks. Such a physician does not belong to his medical society, does not attend medical meetings, read our journals or avail himself of postgraduate instruction. He is a rank outsider in a campaign such as this. We are trying to prepare a list of coöperating physicians in Detroit, who are interested in one or more phases of venereal disease control,

are willing to adjust charges according to the patient's ability to pay, avail themselves of literature and graduate instruction and coöperate in this program. They will form our army in its drive on venereal disease. It is the back-slider, plus a few rare crooks and incompetents, who bring discredit on our medical profession in a campaign such as this. I wonder how soon organized medicine, for its own protection, will develop enough gumption to begin a house cleaning.

One of the problems, which has been brought to light in this campaign, is the lack of insight by the laity, as to the communicability of venereal diseases. We have industrial plants in Detroit, that not only refuse to hire, but discharge any employee suffering from either gonorrhea or syphilis, regardless of its stage. A blanket order has been passed, refusing to re-hire men having syphilis, as long as their Wassermann test is positive. It is very desirable from a public health standpoint to have routine serologic tests in industry but, at least, non-infectious cases found thereby, should not be discharged. Our welfare rolls will be swelled to an unwarranted degree, known cases will be forced into hiding, and discovered cases will be handicapped in securing treatment. Compensation for industrial disease has augmented the problem. This is an urgent matter that warrants some recommendation by the United States Public Health Service and the Department of Labor.

It should be clearly emphasized, as a part of our lay education, that gonorrhea is transmitted only, with very rare exceptions, by sexual intercourse. The main exception, gonorrheal vaginitis, is not a problem of industrial contact. It should be emphasized that the possibility of adults contracting gonorrhea through toilets and in industry, are extremely remote. Likewise, that syphilis is contagious only in its early stages, or roughly during the first five years; that once recognized and treatment begun and continued regularly, infectiousness should be controlled within 48 hours; that later stages of the disease are not infectious, even though open lesions are present; that cases of late syphilis need not be shunned; that the Wassermann test is not a guide to infectiousness; that with the exception of congenital infection, the disease is acquired, almost entirely by direct contact with moist lesions through intercourse

or kissing; that a patient is immune to a new infection of syphilis, as long, but only as long as, he has the disease; that congenital syphilis is acquired from the mother, not direct from the father; that congenitally syphilitic mothers rarely have congenitally syphilitic children, and finally, that congenital syphilis can be prevented if every mother having acquired syphilis, or a history of same, be treated during every pregnancy.

The communicability of syphilis brings up another problem in its public health control. It is only the early case, and syphilis in pregnancy that are primarily public health problems. The late case is an individual problem as with any chronic disabling disease. Therefore, where limitation of funds is necessary, as it probably will be for some time in Michigan, it would be advisable to limit public health activities largely to this group of infectious cases, leaving the management of the frank late case to the patient and his physician.

If our campaign of venereal disease control is to succeed, more trained follow-up workers will be urgently needed. Their efforts should be spent in running down sources, contacts, and lapsed treatment cases, that are potentially infectious. It is doubtful if they will ever be available in sufficient numbers, or it be desirable to use them in coercing late non-infectious cases to continue more than 18 months of active treatment. These late possibly Wassermann-fast cases are a physician-patient problem, and not a public health one. Yet, it is precisely this type of case for which we get many requests for follow-up, because of lapsed treatments. Physicians should not expect to use their health departments or the influence of this national campaign, as a threat to keep such cases under treatment indefinitely. The Detroit Department of Health will coöperate gladly to the limits of its personnel, in fact, urgently desires to aid physicians in contacting all possible sources, contacts, potentially infectious lapsed treatment cases, and pre-natal syphilitic cases. Full powers of enforced quarantine will be utilized where indicated. It is hoped, for Detroit, at least, when funds permit additional personnel, that assistance can be given physicians in urging their late non-infectious cases to continue treatment until a minimum modern

standard of total treatment is administered. We cannot force treatment on such cases.

Our recent prenuptial physical examination law requiring certification of freedom from venereal disease with mandatory Wassermann or Kahn test for both parties becomes effective October 29, 1937. Correspondence with the health departments of the six states having similar laws, makes one less fearful of probable medical problems than on first thought. A possibility of contract medical examinations on a split fee basis exists, but laws penalizing such practice can be enforced, if needed. It is felt that the blanks for certification should be distributed direct to the physicians, county medical societies, or health units, instead of as proposed, only through county clerks. The law clearly states that examinations must be made by licensed physicians, which should curb any tendency to demand free examinations in clinics. If people can afford to marry, they should be able to pay, at least, a moderate fee for examination. No attempt has been made to set up fee schedules and should not be necessary in Michigan. It is to be regretted that a companion bill before our State Legislature requiring a mandatory Wassermann test during pregnancy was defeated.

The prophylaxis of venereal disease is an important phase of our present campaign. Many believe that it is too delicate a problem to emphasize at the present time for fear of antagonizing certain groups. The idea is frequently expressed that the knowledge of and the use of prophylaxis undermines moral restraint and fear of infection, and thus increases exposure. Instead, it is firmly believed on a basis of many years' observation in world-wide military organizations that use of enforced prophylaxis keeps the possibility of infection constantly in mind and reduces the frequency of sexual exposure. Certainly, reliance on moral persuasion has failed throughout the centuries. Moral, religious or other influences should not be neglected, but every weapon of proven value in combatting venereal disease should be utilized. Other states have made definite progress. Supervision and regulation of mechanical and chemical prophylactics by our State Health Department, would be a logical step. Publicity through drug stores and public urinals would help. Finally, chemical prophylactic



stations, strategically located and open all night, should be established in our larger centers of population.

The desire for secrecy, plus avoidance of medical fees, as has been shown by several questionnaires, drives the majority of persons with venereal disease first to the counter-prescribing drug store. This fact is to be regretted and if these diseases are to be stamped out, such sense of shame and false economy must be corrected, or controlled. It not alone causes delay in diagnosis, increases complications and materially reduces the chance of cure, but greatly increases our crop of new cases. It should be the duty of our medical societies and health departments to contact and secure the coöperation of the Retail

Druggist's Association in urging their membership, plus any pressure they might suggest on their non-member associates, not to treat venereal diseases, but to refer such cases to physicians at once.

Time does not permit discussion of many other problems of our current venereal disease program. Venereal diseases can be controlled, and at less expense than any of our major public health problems. The present program will succeed if we give it our enthusiastic support. The necessary funds can be secured, if the program is given such support by our physicians and health departments, plus organized widespread publicity. If the campaign fails, we can only blame ourselves.

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## THE EDUCATION OF THE PUBLIC IN CANCER

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The Michigan State Medical Society through its Cancer Committee has very definitely committed itself to a program of cancer education. Its success depends upon the interest and enthusiastic participation of every doctor in the state. As a result of the experience of the past three years, the necessity of a systematic attack has become apparent whereby, as far as possible, standardized statistical and factual material is disseminated to the public. To this end a large cancer sub-committee has been appointed, representing geographically the entire state upon whose shoulders will fall the bulk of the burden of talking to lay groups. Men have been selected to serve on this sub-committee because of the interest in the subject and their speaking ability. This by no means reduces the responsibility of every physician and minimizes in no way the importance of his assistance.

It is believed desirable to acquaint the public with the prevalence of cancer, a disease which ranks second as a leading cause of death and accounts for nearly 150,000 deaths in the United States annually. In the past thirty years, it has risen from tenth place to its present position and if its prevalence increases at its present rate for the next thirty years, it will kill over a quarter of a million people in this country annually. However, if proper methods are applied and present facilities and knowledge properly utilized, the death rate from cancer instead of increasing in the next thirty years should drop fifty per cent. It could be said to an average audience of one hundred women

of thirty-five years of age each that thirteen of them will die of cancer at the present rate; at fifty years, one out of six. However, statistics have small constructive value and must not be used to unnecessarily frighten those whose fears we wish to allay.

The next logical step is to explain the nature of cancer, the biological differences between neoplastic tissue, between malignant and benign tumors and the phenomenon of metastasis. The important role of the various forms of chronic irritation in the development of cancer should be stressed and lead to the very important subject of cancer prevention. In this connection the removal of benign tumors, particularly of the breast and skin, can be stressed as an important step in cancer prevention. In dealing with heredity, it can be accurately stated that there is a definite hereditary influence in the development of cancer. When discussing cancer biologically, an ex-

cellent opportunity is afforded to explode many of the fallacies and misconceptions held by the public and to replace popular misinformation with true facts. The successful treatment of cancer, consisting as it does of the removal or destruction of the malignant lesions before metastasis occurs, makes the use of surgery, radium and x-ray therapy quite plausible and renders an opportunity to condemn quackery and unscientific methods in general. A generous number of illustrations of successfully treated patients cannot help but be impressive. As nearly as can be estimated, a quarter of million people have been cured of cancer in the United States of which Michigan's share would be about 6,000. The element of delay as a factor in cancer mortality cannot be over-emphasized. In treatable cancer, good results can be obtained in from seventy to a hundred per cent of early cases, and in only zero to thirty per cent in late stages. In other words, early cancer is curable.

Doubtless every doctor who is called upon to give a cancer talk will develop his subject along similar lines. The public, however, is skeptical and certain obstacles, not insurmountable, present themselves.

First, the public openly accuses the medical profession of not knowing the cause and cure of cancer. If it is to be assumed that there is but a single cause and a single cure of cancer, there is some truth to the accusation. Much is still to be learned about cancer. However, as much progress has doubtless been made, as much information added, in the past ten years in cancer as in any other major disease. Much of the present cancer information cannot be applied because of lack of coöperation on the part of the public. People are inconsistent in flaying the medical profession for its lack of accomplishment in cancer. There seems to be no criticism of the fact that the causes of hypertension and arteriosclerosis are unknown and that there is no curative treatment for such consequences as cardiovascular-renal disease, coronary thrombosis and apoplexy. We can control diabetes and pernicious anemia, but do not know their causes. Tuberculosis is still a serious disease and pneumonia threatens to push cancer out of second place as a mortality factor.

I am unable to view cancer as the great mystery of medicine. We know a great

deal about the origin, development and progress of malignant lesions. A pre-cancerous lesion occasionally becomes malignant under observation. It is as easy to understand the mechanics of cancer as of many other diseases. To refer to a cancer "problem" is probably a fallacy because thereby is conveyed the impression that some day the problem will be completely and suddenly solved, as one would solve a puzzle or a problem in arithmetic. Future progress in cancer will doubtless be slow, constant and continuous, but not spectacular.

The next obstacle to be encountered is fear. There are two kinds of cancer fear. First there is the fear engendered by knowingly having the disease or suspecting its presence, which is understandable. But more important is the unreasoning, abstract fear, not of the disease, but of the subject. Many people have their ears, their eyes and their minds closed to information regarding cancer because they consider it a hideous, repulsive subject, one too revolting for their consideration. Much of this attitude is inherent and some is the result of unfortunate contacts or descriptions of ugly, neglected cases which might have been cured had they been attacked in an early stage. Perhaps some cancer talks in the past have been too gruesome. Intelligent people often feel that they must protect their finer sensibilities against such shocks. The public must be made to understand that cancer is not necessarily a foul, unsightly disease and that the subject is not necessarily unpleasant. Cancer talks must be made interesting and instructive, but not obnoxious. Until cancer can be talked about freely and openly, without discomfort or restraint, no real progress will be made in cancer control. Furthermore, no amount of medical knowledge will be applicable unless this barrier of unreasoning fear and reluctance to listen can be broken down.

The public is definitely skeptical about the curability of cancer and while we know that there will be a high cancer mortality for many tomorrows, good results are by no means rare. For the purposes of cancer education, more could doubtless be accomplished with less effort and in a shorter time by concentrating upon accessible cancer—that is, the skin, lips, mouth, breast and uterus. This is an important group. Cancer



of the breast and uterus constitute approximately half of female cancer. It is a group in which early diagnosis can be made and in which prompt treatment produces favorable results. It is necessary to stress good results in any cancer program in order to replace some of the existing, unjustified pessimism with warranted hopefulness.

In accessible cancer lies a fertile field of preventive medicine, especially cancer of the skin, mouth and uterus. Many of the forms of chronic irritation leading to the development of cancer of the mouth can be recognized, removed and corrected. Precancerous skin lesions can be eradicated. Postnatal damage to the cervix can be repaired. Cancer prevention is not a myth but it should be applied to the types of cancer which are associated with demonstrable carcinogenic influences. The best form of cancer prevention consists of frequent, periodic, complete physical examinations or health audits which would detect much cancer in a treatable stage.

Simple rules must be given the public for the early recognition of cancer. The danger of persistent lumps, bleeding, discharge and sores, must be emphasized. A warning regarding the frequent absence of pain must be sounded. The symptomatology of cancer is often varied and complex and it is undesirable to give the public a long list of signs and symptoms and expect cancer patients

to make the diagnosis. It would be better to instruct them to turn to their physician when there is a definite deviation from normal good health and the proper advice will be obtained. A healthful inquisitiveness among people regarding their own bodies should be stimulated in order that obvious lesions can be recognized earlier. It is not infrequent for a woman to apparently suddenly discover a lump in her breast which had doubtless been present for some time.

The public must be informed of the nature and the danger of cancer and the conditions under which the disease can be controlled. Protection against cancer is something real and practical and consists of the application of well established cancer facts. Knowledge disseminated for this purpose must be of a public health rather than a medical nature. A receptive attitude toward cancer information must be created. The prevailing picture of cancer as a hopeless, horrible disease must be replaced by an intelligent constructive interest and a willingness to thoroughly coöperate with medical forces. Cancer must take its place as a clean disease. Cancer information to the public must be educational and free from objectionable features. It must be clearly understood that cancer under proper conditions is curable. Cancer can be controlled only by a prolonged and relentless attack, with common sense replacing hysteria.

## REPORT OF OBSERVATIONS OF THE INSULIN HYPOGLYCEMIC SHOCK TREATMENT ON PSYCHOTIC PATIENTS\*

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The information contained in this report was obtained while watching the insulin hypoglycemic shock therapy as it was carried out on approximately twenty patients over a period of three weeks as well as from conversations with various men associated with this work. Those included are Dr. John R. Ross, superintendent of the Harlem Valley State Hospital, and his associates, Dr. Nolan D. C. Lewis of the New York State Psychiatric Institute and Hospital, and Dr. Harris, who is supervising the treatments there; Drs. Bryan, Sleeper and Cameron of Worcester State Hospital; Dr. Adolph Meyer and Dr. Katzenelbogen of the Phipps Clinic of the Johns Hopkins Hospital, as well as personal interviews with Dr. Joseph Wortis, who is treating some patients in Bellevue Psychiatric Hospital, New York; and Dr. Man-

fred Sakel, who made weekly visits to the Harlem Valley State Hospital and who was also interviewed in New York. Information from so many sources of necessity requires treatment rather by summary than by an attempt to detail a variety of attitudes.

\*Read before the Detroit Neurological Society, March 18, 1937.

It might be said that there are almost as many attitudes toward the procedure as there are individuals associated with it. Again, the picture is further complicated by the fact that the treatment in itself is a complicated and highly variable one which is further changed in detail by each one who is carrying it out, and even its originator, Dr. Sakel, is himself modifying it as time goes on. Therefore, we have the highly complex picture of the varying diversifications of a changing technic. As this is essentially a report of observations, no attempt will be made to completely review the literature.

In brief, the treatment as ordinarily described in the literature,<sup>4,8,9,10,12,13,14</sup> and even in Dr. Sakel's most recent\* article,<sup>11</sup> is one in which the patient is given almost daily increasing doses of insulin until the desired hypoglycemic shock is produced. The dose which produces this shock is continued as the "shock dose" six days out of the week until the desired results are obtained; after which the patient is given less severe shocks sometimes by smaller doses of insulin in the phase known as the "polarization phase." Each treatment is terminated by giving some form of sugar at the indicated time. Usually during the shock treatment, it is necessary to give this sugar by stomach tube, and occasionally intravenously. The time of this termination of the shock is perhaps the most important and the least understood part of the procedure. The purpose of the procedure is to produce what personality changes are possible by insulin shock which Dr. Sakel, from his experience with insulin in treating morphine addicts, adduced would benefit the schizophrenic. Perhaps, briefly, it might be stated that insulin shock produces certain changes either neurological or psychic, or both, which result in some change in the personality which in fortunate cases relieves or destroys the psychosis.

The most recent modification advocated by Dr. Sakel and the one now used at the Harlem Valley State Hospital, where they perhaps most closely follow his advised routine, is one in which the final smaller or polarizing doses of insulin are omitted. Thus, let us say that in an average case the patient is given in the morning of the first

day 20 units of insulin. The effect of this relatively small dose may be very slight and the patient recovers spontaneously, but none the less at the end of three or four hours he is given the interrupting dose of sugar by mouth. With each succeeding treatment, the dose of insulin is increased from five to ten units until the patient demonstrates during the period of hypoglycemia the desired effect. Thus the final or shock dose may vary between wide limits, but might possibly end up at between 50 and 100 units. This shock dose then is continued almost daily until it is thought the patient has derived a maximum benefit from the treatment. Usually, with these larger doses, termination of the shock must be effected through the stomach tube or intravenously. Dr. Sakel is apparently now also leaning toward a more frequent use of adrenalin, to interrupt the coma more quickly. If the patient shows very little or no improvement after from 60 to 70 of these shock dose treatments, he is considered as probably a poor result and discontinued from treatment or at least given a few weeks rest period before making another similar attempt. During the course of the treatment it may appear advisable to change the size of the shock dose, for either the patient may apparently build up a tolerance to the insulin given and not become as comatose as desired, or he may apparently not be able to withstand so severe a dose and show undesirable symptoms, whereupon the desired shock dose is found to be smaller. The final or polarization phase, in which less severe shock is produced in the termination of the treatment, is no longer advised by Sakel because he feels that giving anything less than the therapeutic shock may leave the patient in an undesirable state. He feels that the patient tends to be fixated at the psychic level present at the time of termination of each shock.

Before going further, it might be well to stop for a moment and consider some of the physiological changes which occur as the result of this insulin hypoglycemic shock. Obviously, the administration of insulin lowers the blood sugar, and, as the doses are increased, of course the blood sugar at a set time after its administration tends to reach lower levels. However, there are no really consistent findings as to the lower limits to which it may fall, and appar-

\*At the time of writing, this was the most recent article by Sakel available. Others have appeared since.



ently very little relationship between the size of the dose of insulin given and the depth to which the blood sugar descends. From various sources it is apparent that the true fermentable blood glucose rarely goes below 18 or 20 milligrams per 100 c.c. of blood. The lowest reading obtained was 13 milligrams in one case. When to this is added the non-fermentable reducing substances, which are variable in amount, we may well have an ordinary blood sugar reading of 25-30. It seems peculiar that no lower readings than this were obtained. Certainly not the findings corresponding to those reported in rabbits,<sup>3</sup> in which, due to insulin shock with convulsions, the true fermentable glucose of the blood stream disappeared entirely. In humans the blood sugar has remained at its lowest ebb for one and one-half hours before a convulsion appeared. Lower blood sugar values have been found in humans with widespread liver disease, because apparently there is no glycogen reserve from which to produce circulating glucose in these individuals. Obviously, after the interruption of the hypoglycemia with the solution of sugar by stomach tube or glucose intravenously, the blood sugar values must reach very high levels, later returning to normal.

Intimately associated with glucose metabolism, of course, is that of phosphorus. It is well known that when insulin is given and produces hypoglycemia there is a coincident fall in the blood phosphorus. This is generally conceded as being the result of the formation of hexose phosphate as a step in the formation of glycogen out of glucose. However, it is reported<sup>6</sup> that there is a continued increase in phosphorus excretion in the urine even on the days without treatment, and the final explanation of this is not entirely clear. There is ordinarily found with changes in the blood sugar toward hyperglycemia a compensatory fall in the blood chloride presumably to maintain a constant osmotic pressure. However, when the blood sugar falls due to insulin, although there is a distinct increase in the blood chloride, this is not felt by Chaikelis,<sup>2</sup> in experimenting on rabbits, to be adequately explained merely on the theory of restoring osmotic pressure of the blood because the change in blood chloride greatly overcompensates for the change produced by the fall in blood sugar. Furthermore, this author also points out that the rise in blood

sugar due to adrenalin injection is not accompanied by the expected fall in blood chloride. He proposes the idea that during insulin hypoglycemia there is stimulation for the pouring out of adrenalin into the blood stream which, it is known, influences metabolism in such a way that lactic acid is increased in amount. In order to maintain normal acid base equilibrium in the blood there would be, with the increased lactic acid, removal of a certain amount of bicarbonate. With this change of bicarbonate-chloride ratio in the blood, there would be a tendency for chlorine to shift from the tissue fluids into the blood stream to maintain the constancy of the acid base ratio. Furthermore, he feels the formation of hexose phosphate during the metabolic changes of the blood glucose might also contribute to the shifting of the chlorine from the tissues to the blood. This shift of chlorine to the blood would presumably leave excess of sodium in the tissue fluid. Water from the plasma would tend to shift to the tissues with this retained sodium, in order to maintain isotonicity of the intracellular and extracellular water. These entirely theoretical considerations are thought to be consistent with the changes in weight observed in some of the cases that will be referred to later.

It has been found by some that the injection of insulin causes a drop in the amino-acid content of the blood almost in molecular proportion to the drop in the glucose of the blood, and this phase of the metabolic changes is at present being studied, although too few observations have been made to warrant drawing any conclusions. A marked increase in the metabolic rate is reported by Gross<sup>6</sup> during the treatment with profound insulin shock. It will be noted that his calculations are based on Read's formula, concerning which there is increasing evidence that this is not a true index of the rate of oxygen consumption. However, at present no studies are apparently available concerning the oxygen consumption of these patients during the treatment. There is apparently no more than minimal changes in the blood calcium, inconstantly a rise. Although there is reported a moderate anhydremia of the blood during insulin shock, this is not sufficiently large to account for the supposed increases in the cellular content. Not only do the red cells increase, but there is also a disproportionate leukocytosis.

Changes of the cardiovascular system during the shock treatment are various. In most cases in which the cardiovascular system is not greatly affected, there is little change in the pulse rate even during rather profound shock. There may be rather quick changes in rate, varying possibly from 70 to 90 and back to 70 again within a short time, but this is not considered to be a serious matter. It is explained upon the changes in dominance of the two opposing autonomic controlling systems of the heart. However, there occasionally occurs a very marked tachycardia and when the patient's pulse is noticed to range from 90 to 100, to 110, to 120, etc., thus maintaining a progressive increase in rate, this is considered to be a matter of serious significance and the shock is interrupted. The same holds true for a very marked bradycardia, when the pulse falls to between 30 and 40, which again is an indication for termination of the shock. These variations in rate, when followed on the electrocardiogram, are found to be of nodal origin. There are also certain irregularities of the heart beat which are due to auricular or ventricular extra systoles. The electrocardiogram is supposed by some in studying the heart in insulin hypoglycemia to have a flattening of the "T" waves. This is supposedly due to some alteration in the metabolism of the heart muscle itself, but is far from a consistent finding, and, in fact, others just as often find increased amplitude of the "T" wave. However, there is found an increase in the Q-T interval. This reveals a perfectly normal Q.R.S. complex, but since the entire interval is prolonged, it suggests that there is a slowing of not only the period of contraction but also of the period of relaxation in the cardiac cycle. It is interesting that this E.K.G. change is also found in disturbances of metabolism associated with low blood calcium. Blood pressure as a rule shows no marked change, although there may be some increase in systolic and lowering of the diastolic pressure. Obviously, if there is a sudden drop in the blood pressure, a weak thready pulse, signs of cardiovascular collapse, the coma must be terminated.

The respiratory mechanism not infrequently shows distressing complications that must be watched. Apparently there are a few patients who go into a respiratory collapse in which the respirations become slow-

er and shallower during the shock treatment. This is thought to be of sufficient significance to terminate the shock. Apparently severe bronchial spasm has been observed in which there is very marked expiratory obstruction, the lungs finally becoming ballooned up with air, and this may in itself go on to asphyxia if not interrupted. Spasm of the glottis is not infrequently found, evidenced by loud, rumbling respiration which is not relieved by changing the position of the patient's head in an attempt to shift the tongue, which may have fallen back and caused a similar picture. If this continues over a period of time and interferes with the respiratory efficiency, it is thought best treated by terminating the shock.

There are few gastrointestinal symptoms to be noted except that occasionally a patient is found who apparently does not absorb the sugar solution which is given to terminate the coma. These patients seem to go into an even deeper coma after being given the sugar solution, and if they do not begin to return to consciousness within approximately half an hour, other things being equal, it is usually advisable to give them intravenous glucose, from which they react quite quickly. Often it is noted that when they do start to wake up they vomit the sugar solution. Explanation for this is not clear, but it is suggested that they have considerable loss of tone of the stomach, diminished peristalsis during the coma, so that the sugar solution is not forced out into the duodenum, where it can be quickly absorbed. Usually after a short time they will be able to drink some more sugar solution, but occasionally gastric lavage is necessary. It is interesting that in none of the patients that were observed personally was there any spontaneous desire for food as the blood sugar was becoming lower preliminary to the appearance of coma. However, when they are brought out from the coma with the sugar solution, they are often quite hungry. However, it is quite true that some of the patients after several days of treatment will have a marked increase in appetite not only for the noon meal but also for other meals taken that day, and also on the rest days when they receive no insulin. There are those who feel that the gain in weight that the patient shows during the treatment is a



good index of the amount of improvement shown. However, this is denied by others who find that most of the patients gain weight whether they improve or not. There is occasionally noted during the deep coma, and especially with agitation, incontinence of the feces.

It was found at the Harlem Valley State Hospital by routine morning urine examination that about 50 per cent showed a mild glycosuria even though the previous day they had had no treatment. On one or two occasions a slight trace of albumin was found. Apparently water balance studies have not been accurately done. It seems that this is indicated. One girl was noted to have a slight, but somewhat increasing puffiness of the face, although there was no obvious pitting edema to be noted anywhere. She was given a modified Mosen-thal test, which revealed one of the specimens to have a specific gravity of 1.028, which was thought to show adequate concentrating ability of the kidneys, considering the fact that there was no well established dehydration before this. There was no nitrogen retention. Another patient at another institution, over a period of about four or five weeks' treatment, gained approximately 25 pounds and then for some reason which they could not explain, in one week lost approximately 13 pounds. Furthermore, Sakel, himself, has said that the gain in weight that these patients make during the treatment may be rather quickly lost after discontinuing it. When taking these facts into consideration with the already mentioned possible changes in the acid base balance and retention of sodium in the tissues, it is highly suggestive that probably a large portion of this gain in weight is in the form of fluids in a generalized subclinical edema which may be quickly lost. Again, it was noticed in another patient who had to void immediately after being brought out of coma, that the urine was basic and in another case the urine was neutral. No control tests have been carried out, but this phase of the metabolic processes may be worthy of further investigation. Certainly, accurate water balance studies should reveal some interesting information.

Many of the motor and neurological changes are well known to all and will only be given here in the merest detail. As is so

often found in normal or diabetic individuals who have received an overdose of insulin, there occurs first a certain quieting of the patient, although with some uneasiness, and at this time they may have a feeling of chilliness. Later they really desire to go to sleep in spite of occasional nervousness. At about this time they very frequently appear somewhat pale. There may be beginning perspiration which may go on to a very marked drenching of the patient and the bed clothes. On the other hand, many patients perspire not at all. With the perspiration there is usually a marked increase in salivation, and at this time patients are usually semi-conscious but can be aroused. Usually it is not long before they become actually unconscious and will drool the saliva out of the mouth if the head is turned; the eyes have a tendency to roll from side to side. At about this time there is loss of the abdominal and cremasteric reflexes. From this point on they may remain quiet and go slowly into deeper coma, during which there rather constantly appears positive Babinski, Oppenheim and Chaddock signs, usually increased knee jerks, occasionally true clonus, appearance of the Hoffman sign, finally the loss of the corneal reflex, and when they go beyond this into an even deeper state, there may appear a true areflexia throughout with markedly diminished or absent light reflex. On the other hand, the patient after going into mild shock may not proceed along this quiet course, but rather have a violent and stormy time. There may be marked fighting movements, stereotyped activity such as kicking the legs up and down as if riding a bicycle, or mannerisms of the hands. Again, frequently there is shouting, at which time it is thought from the content of the words that the patient is reacting to some part of his psychosis or conflict state. There is also obscene language used, and forceful spitting out of saliva is not particularly uncommon in these agitated reactions. The third type of reaction which may be associated with the above, but often is not, is one in which there appears in one or all of the extremities first slight twitching of some of the smaller muscles; this progresses to clonic or tonic spasms of that and other extremities, even including the neck, with the production occasionally of opisthotonos. This is allowed to go on for a period of possibly

a half or three quarters of an hour if not too violent. Then ordinarily the patient will drop off into a considerably deeper coma. This is also true of the agitated patients who are shouting and swearing. Usually, it is desirable to allow the patients to go through these active or violent stages if physically possible and proceed into the following deeper coma from which they are terminated by the sugar solution. Of course, it must be remembered that at any time during the course of the hypoglycemia, and particularly during the deep coma stages with the activity noted, that the severe convulsive seizures may be initiated, which are terminated as quickly as possible. The convulsion, of course, is a real threat to life.

It is interesting, as the patient returns to consciousness from his state of deep coma, that the disappearance of the pathological reflexes already referred to often occurs in just the opposite order in which they first became manifest. This is certainly not a consistent finding but is interesting when noted. Thus, among the first abnormal reflexes to be lost often is the Hoffman sign, and the corneal reflex returns while Babinski's sign may still be present, but this latter soon becomes absent as consciousness approaches. Finally the patient may be up and about for almost half an hour before the abdominal reflex returns. No one apparently will definitely make a statement as to whether or not there is any phylogenetic or ontogenetic significance to this appearance and disappearance of normal and abnormal reflexes. However, it has been thought<sup>1</sup> that to some noxious agents the older and more well established parts of the nervous system are relatively immune, but the newer, phylogenetically more recent systems are much more susceptible. The abdominal and cremasteric reflexes, which are among the last normal reflexes to be established in the development of the infant, are the first to disappear during the coma and the last to return after return to consciousness. The corneal reflex, established early in life, is among the last to go and first to return during the same process. The lateral rolling of the eyes may be thought of as a counterpart of a lateral nystagmus—an abnormality of a phylogenetically recently acquired movement of the eyes. This lateral motion is one

of the early signs of coma and persists until the patient has almost returned to consciousness. Babinski's sign present in the infant during the first year of life is evidence that the neurological mechanism for the lower leg is not as yet completely established while this mechanism for the arm has progressed much farther. During hypoglycemic shock coma Babinski's sign appears often long before Hoffman's sign and persists longer during the return to consciousness. However, this point of view must be considered as only tentative, for apparently these relationships are not to be found consistently.

What might perhaps be termed the psychic changes observed during the treatment are, as one would expect, manifold. Perhaps the most constant effect of the insulin hypoglycemia and shock is seen in the lessening of the subjective tension and the quieting of the agitated, disturbed, overactive patients. It may, at this point, be mentioned that insulin has also been used to cut down the psychomotor activity of cases of acute mania.<sup>5</sup> Again it was observed during the shock treatment, even in some possibly borderline cases with very severe psychoneurotic manifestations associated with restlessness and marked subjective tension, that the insulin hypoglycemia had not only relieved the restlessness but showed considerable relaxation of the subjective tension and anxiety, even in the insulin-free periods during treatment. Then again during the hypoglycemia there are in many patients evidences of regression of the psychosis to a former level. Thus, a patient who may reveal considerable confusion, disorientation, with little tangible content to his thought processes, will, during the hypoglycemia, show some clearing of the confusion and a thought content almost identical with the psychosis as it was several months or years before. This may go on so that even during the insulin-free period the psychosis remains in that earlier period. Sometimes with continued treatment, further regression cannot be brought about, but again by continuing the treatment even this may clear up with a favorable result. There often occurs, during the hypoglycemia, a certain apparent lucidity and appreciation of clearing of the thought processes which was not formerly present. Again during the shock, in muttered or shouted utterances, there may be brought to the fore psychic traumata



which occurred years before, even in childhood. At times the patient will state that, when going into the hypoglycemia just before consciousness is lost, he had peculiar visions or sensations which, in their content, may be interpreted as a manifestation of true splitting of the personality. In the type of patient who is variously described as empty, who apparently has almost no thought processes, with no expressed content, who is totally inactive although not necessarily stuporous, there occurs usually during the early stages of the hypoglycemia what is called "activation of the psychosis." That is to say, the formerly empty or mentally void psychotics apparently become stirred up and they begin to move about spontaneously and utter a few words. This, they are encouraged to do by attempted conversation on neutral subjects and even by a certain amount of physical manipulation in an attempt to keep the active process going. In this type of case the patient is terminated early during this activated phase.

Apparently, all patients not only during and immediately after the hypoglycemia, but also during the entire course of the treatment, are particularly vulnerable to psychic traumata which might come from a too inquiring course of questioning concerning some of the more fundamental aspects of their psychosis. This Dr. Sakel feels very strongly and also contends that a consistently hopeful and encouraging attitude should be maintained throughout, for apparently a scientific skepticism can do more harm, at times, than a hopeful optimism can do good.

These varying manifestations of the psychosis may be so handled as to lead the patient out of his psychosis by varying the depth and length of the shocks to which he is subjected, and herein lies the problem. In ideal at least, as the treatment progresses, the lucidity and freedom from psychosis which is apparent during the hypoglycemia, continues on after the hypoglycemia for longer and longer periods until finally the patient is relatively clear all during the day. Then the reverse reaction occurs in which the only psychotic symptoms are noticed during the hypoglycemia. Even then the treatment is continued until during this hypoglycemia little or no psychopathology will be noticed. But this is apparently not a

clear-cut progression in actual practice. On the other hand, the so-called empty case becomes activated during the hypoglycemia in the early stages and may remain activated during the rest of the day. As this is a fixation at an earlier state in the psychosis the patient is no longer considered an empty case and treatment is then changed to deep prolonged coma, which is continued as above described for the case in which the psychosis maintains the more dynamic form.

In brief, Sakel theorizes, in part, that the effect of insulin is in putting cerebral conduction paths out of action level by level and that on their recovery the more fundamental normal relationships are assumed.

Dr. Sakel's great forte is apparently being able to determine the optimal time for the termination of the hypoglycemic shock. This, at least from the observations made, is not only a very difficult thing to know, but also is complicated by various factors, for in a rather large percentage of the cases the coma is terminated for purely physical reasons. Thus, there may be vasomotor collapse, marked tachycardia or bradycardia, the respiratory abnormalities already noted, the exhaustion of the patient from his violent overactivity during the hypoglycemia, or the appearance of convulsions. From these manifestations it is obvious that there are certain contraindications for the treatment in the selection of cases. Evidences of cardiovascular disease in the form of hypertension, valvular heart disease, myocardial insufficiency and particularly disease of coronary arteries are felt to be contraindications. However, one or two cases of mild coronary disease have been treated with great care successfully. Any evidences of pulmonary or renal pathology are also felt to make the patients highly undesirable subjects for the treatment. Pathology of the pancreas is also put in the same category, for one of the deaths reported was due to acute necrotizing pancreatitis. Before even attempting treatment it is highly advisable that the patient be a good physical risk. A detail in this regard is perhaps important here; it is highly desirable for obvious reasons that the patient have adequate and easily found superficial veins.

If during the course of treatment, the patient develops for any reason a fever, the treatment is stopped for a few days until this subsides. This is also true of the de-

velopment of albuminuria, jaundice, severe diarrhea or other evidences of active pathology in any of the viscera. Also, if during the treatment convulsions occur, treatment is suspended for at least one day after that. Another complication is "after shock." Occasionally a patient is found who may have his ordinary shock treatment during the morning, be terminated without complications and eat his regular lunch. However, three or four hours after this meal he may again have symptoms of weakness, nervousness, perspiration, and, if not given further glucose by mouth at that time, may fall again into profound shock and need the indicated procedures. This is not an indication for cessation of the treatment the following day, but suggests that the dose of insulin be somewhat decreased. The further details of the special equipment, diet, and special nursing attention, etc., need not be gone into here.

The shock dose as has been stated is a very highly variable one. Marked hypoglycemic shock has been reported from doses as low as 20 units and a case was personally observed in which the dose of 275 units produced only moderate drowsiness with some restlessness and no real coma. Again, cases were found in which the dose of insulin was gradually increased up to 190 units without a very marked effect upon the patient. However, at 195 units rather profound shock was obtained. Merely from an experimental point of view, the dose was then gradually reduced and it was found that in this particular patient 100 units of insulin would produce the desired results whereas during the initial progressive increase in the dosage 100 units produced very little change. Furthermore, other cases which are maintained on exactly the same dose of insulin for a period of time will one day have severe coma, possibly the next day only go mildly into shock and then again the third day may have a convulsion, so that it may be said that there is very little constant relationship to be found between the dose of insulin given and the reactions of the patient. In establishing the shock dose the method of trial and error must, of necessity, be used. Some of those using this treatment institute a variation in which, if after an hour and a half or two hours following the insulin the patient does not appear as if he were going to have as profound coma as

desired, a second smaller dose of insulin is given with apparently a rather quick production of the desired coma. Also other supplementary drugs such as atropine have been used during this treatment. However, these technics are very limited in number.

Perhaps a few illustrative cases will help to present a better picture of some of the mechanisms involved as well as the variability that is seen during the procedure.

*Case 1.*—William W., aged thirty-eight, had apparently been a very adequate individual until about three years ago, although there was a very definite extra-marital alliance. His change in mental activity began about the age of thirty-five, when he became extremely interested in philosophical problems and tried to work out a system of morals which was based somewhat on Einstein's theory of the universe. This created within him a marked state of subjective tension which caused him to become very restless and sleepless. There were only occasional emotional outbursts, but he required fairly heavy sedation at night. He denied hallucinations. He stated that he felt much better after about eight or ten periods of quite deep coma. On going into hypoglycemic coma he often exhibited marked restlessness with a tendency to fight. One morning when he was coming out of the coma, he became unusually agitated and required more than five men to prevent him from falling out of bed and hurting himself. He stated later, "I must have fought all that stuff out of me during the tussle that morning." He was then showing none of the restlessness or anxiety nor did he have the feeling of subjective tension and inability to sleep that he had demonstrated when he came into the hospital. Recently, word has come that after approximately twenty-six treatments he was considered recovered. After a week without insulin he suffered a relapse, but with the resumption of treatment he is again improving.

*Case 2.*—Another case showing interesting subjective personality sensations is that of Jeroma A., aged twenty-two, diagnosed paranoid dementia præcox of two years' duration. He was rather fearful during the initial stages of the increasing doses of insulin, but finally having reached the dose of 115 units he told of an interesting experience as he was going into hypoglycemia which he remembered the next day. He said that he appeared to be able to see himself as if he were cut into two individuals and that he, the third person, realized that he did not fit into either of those other two individuals, who were also himself. He said he could not explain this. As the dosage of insulin continued to be increased slowly, he appeared afterwards to have longer periods of lucidity with the demonstration of considerable affect. The latest word concerning him shows him much improved although still occasionally hallucinated.

*Case 3.*—Another case which showed interesting features is that of Robert Van L., aged twenty-two, who was diagnosed dementia præcox, simple type, duration three years or more. At the age of seven he was assaulted by a truck driver in the form of pederasty. This apparently passed without any obvious complication at the time. Later, when sexually mature there was some conflict over an unhappy attempt at sex relations. When treatment was started he was reserved, disinterested and would not talk for long periods. He denied hallucinations at this time. During the beginning of increasing



doses he said that he really felt better physically after the third dose of insulin, which in this case was 45 units. During the fifth injection, which was 70 units, he became rather disturbed during the hypoglycemia and shouted out, "You know what prick the needle means." He also kept repeating that seven was his unlucky number and apparently was in conflict over it. If one is really looking for it one can see some connection here between his remarks during the hypoglycemia and his being assaulted at the age of seven. He was finally carried on up to deep shock at the dose of 100 units, and apparently has improved some for he is clearer mentally, shows considerably more affect than before and is more interested and active about the ward. When the last information was obtained he was still under treatment.

*Case 4.*—Sally B, aged seventeen, diagnosed paranoid type of dementia praecox of over one year's duration. Family history is very unfortunate for her in that her mother and her mother's father were both psychotic. She herself was an illegitimate child and has been adopted and raised very carefully by foster parents who themselves are quite unstable. She knows that she is adopted. As a child she is said to have been a sweet and lovely little girl, although she was not bright in school. She is interested particularly in piano and vocal lessons and was sent to a convent school. She is very much more attached to her step-father than to her step-mother and she confided only in him. She was always shy about boys. Separation of her foster parents in 1935 apparently upset her considerably. She became nervous, destructive, irritable, did poorly in school and stated that voices called her a "bad girl." She blocked and was impulsive. At the time of the separation of her foster parents she was urged against her will to sign a paper stating that the foster father, whom she loved, was continually coming home drunk, causing disturbance around the house and maltreating her foster mother, whom she hated. At the time of admission to the hospital she was considered violent, suicidal, very resistive, required tube feeding, continued to be actively hallucinated and required restraint. She would break windows and would occasionally be incontinent. Her thoughts were scattered and irrelevant. When treatment was started she was an extremely resistive, fighting, violent type of patient. After the first three increasing doses she was very definitely quieter, but still when she was brought to the ward she called the nurses "bitches" and continued to spit at them. She did not show this behavior toward the male attendants or doctors. At about the seventh injection, which was of 50 units, she was very much more quiet and co-operative. Quietness continued during the day and after that the resistiveness, spitting, shouting out of "bitch" were only present during the period of hypoglycemia. During the rest of the day she was co-operative and pleasant although very definitely shy, retiring and somewhat unproductive. Through a rather prolonged period in which she remained somewhat the same, it was found that even after her twenty-fourth treatment which had finally been taken up to 75 units, she was still actively hallucinated and Dr. Sakel at that time felt she should be given even deeper coma. He thought that probably the appearance of a convulsion might be helpful in her case. It was a great and delightful surprise to learn recently, by correspondence, that after her twenty-ninth treatment she was considered recovered. This illustrates the quieting of the excited patient with improvement during the day, as well as reactivation of the psychosis during the hypoglycemia.

*Case 5.*—An attempt at activation of a psychosis was made in the case of Ida S., aged eighteen, diagnosis—catatonic dementia praecox with hebephrenic features, duration three years. In January of 1934 she began to think that men were around her for sexual purposes and that she was going to have a baby. Her appearance became sloppy. Finally she heard voices coming to her through the steam pipes saying that she was a bad girl. She slowly showed less and less activity, became more self absorbed, idle, required spoon feeding, became untidy, sat with merely a blank expression on her face and occasionally showed cerea flexibilitas. She was started on gradually increasing doses of insulin, but they were increased very slowly. After she had had ten injections the dose of insulin had only reached 50 units. She would have to be brought into the ward and put to bed. She would immediately flop down in a characteristic position on her side and only show spontaneous movements of resistance when an attempt was made to give her the insulin. Any attempt to converse with her, to get her to make spontaneous movements or produce change in facial expression were entirely unavailing at this time. However, after about an hour and a half following the insulin, the physician would go in and attempt to talk to her about neutral subjects that might interest her, possibly starting tickling her or moving her about in bed and she would occasionally wake up a little bit, occasionally slap back at him, look with a more intelligent bright expression and sometimes would spontaneously smile and answer in monosyllables. When there was produced as much spontaneous activity as was thought possible during this period she would be given her glucose, which she willingly drank and then she was given her lunch. This case is also still under treatment. In theory it is hoped she can be brought out of her lethargy and fixated in an activated phase.

In regard to the type of case best suited for insulin therapy, it can be said that in general the shorter the duration of the psychosis the better the prognosis and that the paranoid type shows the best results. Dr. Sakel prefers early cases to be under six months duration. A classification of types of schizophrenia with regard to their chances of benefiting from insulin shock therapy and with regard to the kind of shock to be used, follows only in small part a classification based on clinical types. Rather the depth and severity, and the degree of the dynamic manifestations of the psychosis tend to decide the type of shock advisable as well as influence the ultimate outcome, which is also contingent upon the duration of the disease and the patient's response during treatment.

Wilson<sup>13</sup> takes a classification from the literature supplemented by interviews and personal observation of the procedure in continental Europe. She states that the paranoid type most often shows the orderly progressive type of improvement and is greatly benefited by deep coma. When there



are depressive hypochondriacal delusions present in the schizophrenic, the outlook is less favorable and the course during treatment more irregular. In catatonic excitement the course is also irregular but lucidity may come suddenly even though the treatment may be of long duration with the careful avoidance of psychic noxæ, hunger excitement and interruption of shock at an inopportune time. In stuporous cases the improvement is not so regular and often a considerable period of treatment is required before activation of the psychosis appears and considerable variation of the degree of shock may be necessary.

She gives the opinion of the European workers as being that they really cannot say that any particular group of patients will or will not react favorably and that in an individual case prognosis must be guarded until after treatment has begun.

The extent to which this treatment is being carried out in this country is at the present time almost impossible to determine. Of the known cases being treated or having been treated at the Harlem Valley State Hospital, the Worcester State Hospital, New York Psychiatric Institute, Bellevue Hospital, Bloomingdale Hospital, The Phipps Clinic and other hospitals near Baltimore the total is approximately 120 cases.† However, there are probably a great many others being treated that are not included here. This widespread use of the treatment, of necessity divides the entire group up into individually small series of cases in which percentage values are not highly significant. During the six weeks' course when Dr. Sakel was giving instruction at the Harlem Valley State Hospital twenty cases were treated. At the end of this time there were nine cases which were considered sufficiently improved to be at home. There were also nine cases that were thought to be improved but should remain in the hospital. There were two cases which were considered to be entirely unimproved. Of the nine cases that went home, one of them has now returned for further treatment. Another case is reported as still showing very definite paranoid ideas while at home and the relatives find some question in their minds as to

whether or not she should return to the hospital. Two of the cases are thought to be very much improved and have remained out of the hospital for approximately four months and are making a good adjustment at home. Another case is particularly interesting in that he is one of a pair of identical twins. In these two individuals the psychosis showed considerable similarity, not only in content, but also in the time of inception. The brothers came into the hospital only a few months apart. One brother is now home, having received the treatment, and making a fairly good adjustment. The other brother is still in the hospital and did not receive the treatment. Of the nine improved cases that had to remain in the hospital, six of them were being given their second course of treatment. Apparently, this second course is but slightly more beneficial than the first. In other hospitals visited, where groups of twenty and twenty-five cases have been treated or are still being treated, various results are given. In one place they may feel that two or three cases showed a very remarkable recovery, approximately four or five others showed definite improvement and the rest considered to be unsatisfactory or are still being treated. These are the usual results although in one hospital they report eight out of ten to show excellent improvement.

Apparently, most observers agree that the time has not yet come when we can in this country fairly judge of the benefits of this form of therapy. Almost everyone in charge of treatments agrees that he is still feeling his way and is very interested in having more cases treated so that a more accurate opinion can be formed. Furthermore, there is a great amount of confusion concerning the whole problem. It is not unusual even among competent psychiatrists to have less than 80 per cent agreement as to whether or not schizophrenia is really present. Certainly there are many cases in which there would be a wide divergence of opinions as to the diagnosis. Furthermore, on top of this there is apparently considerable disparity in opinions as to what is and what is not clinical improvement. Dr. Sakel spoke of patients returning to work who were better suited for the job than they ever had been before in their lives. From here we may go on down to a very slight improvement in which the

†The present estimate of number of cases treated throughout the United States and Canada is now probably well over 600 cases up to January, 1938.



patient who formerly was entirely stuporous had to be tube fed, can now feed himself but is otherwise practically the same. Certainly there is a large variable subjective factor both in making the diagnosis and in judging the amount of improvement that occurred. Furthermore, there is apparently very little agreement as to just what coma is or how far down the line of unconsciousness the patient has to progress for coma to exist. At one hospital when the patient's eyes have begun to slightly roll from one side to the other, when he refuses to swallow and when the saliva, which may be slightly increased, drools out of the side of his mouth he is considered to be in fairly deep coma. On the other hand, it is very obvious that Dr. Sakel does not mean this but feels that coma has not become actively manifest until there are signs of changes in the reflexes. Sometimes he even wants coma deepened up to the time of the loss of the corneal reflex. Certainly, there is great confusion at present not only of opinion but even of terminology and definition, which is further complicated by the individual variations of the so-called Sakel method as seen in different hospitals. The various factors which Dr. Sakel himself stresses, of the optimum time for terminating coma and the kind of coma desirable, add other features which will make reported results difficult to compare.

Possibly, an objective way for controlling some of the variable factors will come out of the use of the electro-encephalogram which has been employed at the Worcester State Hospital and elsewhere for a considerable period of time.<sup>7</sup> This machine, to describe it in a highly superficial and inadequate way, is somewhat analogous to the electro-cardiogram in that it appreciates and magnifies changes in electrical potential within the mass of an organ. With the electro-encephalogram there is measured the changes of potential that occur in the brain as manifested in a certain portion of it. It is a very delicate and variable kind of measurement, but apparently in well controlled work shows definite differences between the normal and the schizophrenic. In taking readings with this machine during insulin therapy they find a very distinct change as coma appears. This change apparently does not vary markedly with the increasing depth of the coma, but is im-

mediately brought back to almost the former level in certain respects upon the administration of glucose and as the patient returns to consciousness. It is found that the tracings taken before and after the treatment with insulin show a difference in that the latter more closely approaches the normal than the former. Furthermore, as the treatment goes on, the tracings become more and more like the normal. They have one case which is far from conclusive evidence, but none the less of a high degree of interest. This individual was treated with the insulin shock method and improved clinically and this was reflected in the electro-encephalogram. Since that time he has been at home at work and occasionally returns to the hospital for monthly supervision and the tracing is taken again. Apparently, before clinical relapse is evident, the electro-encephalogram will show some small but definite changes which are suggestive that the schizophrenic process is returning. This has been confirmed by subsequent actions and symptoms of the patient. He is then given one or two shock doses of insulin, whereupon the clinical improvement is evidenced. The electro-encephalogram shows a return toward the normal and he is again sent out for a month or so to return and have the process repeated if necessary. This machine, of course, is still in its embryonic stages, but will be worth following as a possible mechanical means of helping us out of the difficulties into which our subjective reactions cause our opinions to be tangled.

There is, perhaps, only one observation to be made from a survey of this great mass of variable factors in which the treatment is now steeped, especially in this country. It is possibly the newness and inexperience with the treatment in this country that is responsible for the relatively poor results when compared with the European reports. It is quite true in general that those beginning with this treatment have great anxiety and fear concerning it for the patient and do not dare to carry on the coma to the depth that Dr. Sakel might desire. Satisfactory results seem to be almost in proportion to the depth of coma. Thus, Dr. Sakel and his group get the highest percentage of good results. Those in this country who most closely approximate him in the depth of coma attempted, get better



results than those who follow Dr. Sakel's method only but slightly in regard to coma and get probably the poorest results. Possibly this is a true observation, at least it is apparent at this time.

We have been so conditioned against allowing insulin shock to occur and especially against its continuing in the treatment of the diabetic that it is only with the greatest difficulty that we as physicians will allow ourselves to stand idly by and watch our schizophrenic go deeper and deeper into coma when we have ready at hand an easy means of preventing it. Yet, in certain cases it appears that this deep coma is the most beneficial. Finally, it can be said that in addition to being in many instances a real threat to the patient's life, the procedure is a highly individualized one which must take into account the particular responses of the patient and must be varied in so many ways that in the end only experience can indicate the best path to follow. This experience requires time, and time alone will show us not only the final benefit to the patient, but also the ultimate place that this procedure will hold in the field of therapy.

The author wishes to express his gratitude to the various men mentioned at the beginning of this paper who have willingly given of their time to explain the treatment and tell of their experiences with it. He is particularly indebted to Dr. John R. Ross, Superintendent of the Harlem Valley State Hospital, for

his unusual spirit of coöperation in not only allowing the author to use the case history material included in this report, but also extending to him the privileges of the Hospital for a three weeks observation of the treatment there. Many thanks are due to Drs. Gaulocher, Rossman, Cline and Schwoerer, who are personally carrying out the procedure at the Harlem Valley State Hospital, for their interest and patience in demonstrating and explaining the details of the treatment as well as for their coöperation in keeping the author posted from time to time of the progress being made in the patients that were observed there.

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### Tracing of Syphilis Through Common Ailments: Clinical Lecture at Atlantic City Session

A. Benson Cannon, New York (*Journal A. M. A.*, July 31, 1937), points out that the present study was originally conceived as part of a larger one dealing with the accomplishments of arsphenamine, in the treatment of syphilis of all stages. For this purpose a systematic record was kept of all adult patients admitted to the department of dermatology from the spring of 1935 to the spring of 1937 whose ultimate diagnosis was syphilis. In the course of this study it became increasingly apparent that a large proportion of the patients so admitted arrived in this department by accident rather than by design, having presented themselves originally for some complaint totally unconnected with syphilis—at least in their own minds and frequently also in the opinion of the admitting physician. The approximately 600 cases of syphilis recorded to date are unselected, then, as regards latency and represent all syphilitic patients who were treated with arsphenamine during any or all of this period. It leaves out of account those who received only intramuscular injections and/or silver arsphenamine. Among these 600 cases there were 300-odd admissions in whom active syphilis was not at first suspected. Not until commonplace injuries failed to heal after weeks or months of treatment

by ordinary measures were some of these patients discovered to have a positive Wassermann reaction and some a history of a previous infection, overlooked or passed by as irrelevant to the present complaint. The mystery of the slow healing operative wound—even after the extraction of a tooth—is often solved by the simple procedure of taking a blood test. It was found that a surprisingly large proportion of these patients had presented as their chief complaint some ailment commonly encountered in general practice under the names of gastro-intestinal disorders, chronic disorders of the respiratory tract, urinary symptoms, gynecologic ailments and miscellaneous arthritis, diabetes, hernia, goiter and the like. The present report attempts to describe, in a selected group of cases, the methods by which other causes were eliminated, and the symptoms were traced to a syphilis heretofore either unsuspected or supposedly inactive. Symptoms which brought patients to the clinic, the diagnostic procedures, including laboratory tests, x-ray examinations and pathologic changes, the evidence for syphilis and the treatment and its results are described by the author in the hope that this approach, by symptoms rather than systems (the usual textbook method), may prove of considerable interest and some practical value.



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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### TREATING MIND AND BODY

THE leading paper in this number of THE JOURNAL, by Dr. Reynolds of Boston, discusses an interesting, if not a somewhat neglected, phase of medical practice. Time was when the family physician knew not only the organic ailments of his patients, but also their environment, particularly such obstacles to mental well-being as perverse "in-laws," so that he was able to estimate, in a crude way, how much of the ailment was due to a disturbed digestion and how much to an obdurate mother-in-law, as the case may be; in his ministrations to the patient he prescribed accordingly. The modern, up-to-date doctor, while more scientific than his ancestor in the profession, has not had the same opportunity to become acquainted with the environment of the pa-

tient. Sometimes obscure or atypical gall-bladder symptoms or those suggesting peptic ulcer can be cleared up under an ideal mental adjustment.

Dr. Reynolds, in two or three cases cited, shows the effect of environmental factors upon not only the mental but the physical health of the patient. For the busy doctor, the patient's background may be studied by a trained social worker. It would be ideal if this were possible; and doubtless in clinic groups, it may be found satisfactory. However, with private patients, we fail to see how this duty can be relegated to anyone else. By judicious questioning, the doctor should, however, find out for himself the patient's mental reactions, for patients are apt to be reticent in the presence of third persons. Of course, a thorough physical examination, together with all indicated laboratory aids, must be performed and the possibility of any organic lesion eliminated before one is justified in assuming that the trouble is entirely mental. A competent physician will not pass up the patient in whom he fails to find any positive evidence of disease. He should act as father confessor if he has the confidence of the patient. Patients are often greatly benefited through what has been aptly termed mental catharsis. The doctor need not be a psycho-analyst or a psychiatrist to render important service to his patient. In fact, the general practitioner in whom the patient has confidence is a much greater physician than the skilled psychiatrist who may be a stranger.

Dr. Reynolds' paper is a plea for a close study of environment factors, as well as an intimate knowledge of the patient's physical condition, which may now be presumed to be recognized and treated seriously by the majority of physicians.

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### COOPERATIVE MEDICINE

FROM Ann Arbor is announced a half-baked plan for the coöperative practice of medicine. The University Medical School and the University Hospital have nothing to do with it and, so far as we know, the University is not concerned with it at all. The plan roughly, as announced in the newspapers, is to collect from each of 200 or 250 families, twenty-five dollars.

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For this, the family member is to receive all necessary medical care for one year, including medicines. Confinements, where indicated, are to be ten dollars each. While the scheme was incubated and hatched in the mind of a non-medical instructor, as mentioned, it is apparently a purely individual matter so far as the authors of it are concerned.

We are not going to attempt to criticize it. So far as the medical profession is concerned, each member has his own attitude toward such movements. That attitude may be prompted either by experience or surmise. The coöperative medical service idea is contrary, however, to a large portion of the favored methods of medical practice.

Regarding coöperative movements of any kind, our experience is, of necessity, limited and our knowledge is mostly the result of reading. Most of the schemes proposed in the United States have been those employed with greater or less success in European countries. Even though they may work satisfactorily in Europe, there is no assurance that they would be satisfactory here.

However, almost while in the act of reading the newspaper account of the Ann Arbor plan, the *Manchester Guardian* arrived with an article\* on the coöperative movement in Great Britain.

"Everyone who looks at the coöperative movement," writes the *Manchester Guardian* reviewer, "with a sympathetic eye or knows anything of its remarkable history over the last century must have the feeling that there is something wrong with it, that it is not half as good as it ought to be. . . . Yet it does not play the part in the national life that one would expect from its size, its financial strength, and its considerable tincture of practical idealism. It throws up few or no national figures known outside its own ranks. The cynical are often heard to marvel at the miracle that a movement so shot through with mediocrity should yet flourish with such success. . . . Why, with a membership covering half the families of the country, does it only do a ninth of the total trade? The inquiry set out to find the explanation. It is a hard saying, but largely true, that the coöperative movement does not know where it is going. It has

failed to work out a new philosophy of coöperation after the older Owenite ideal has been abandoned, and its influence in the realm of ideas has, in modern times, been negligible. Educationally also the movement has lost its way. After many decades of much valuable achievement the movement has reached a phase where the original impetus has worked itself out. . . . Then, again, the coöperative press lacks distinctive character. Many coöperative journals are unworthy of the movement they represent. They are dull, unattractive, lifeless, and frequently unreadable without a great effort. . . . Co-operators will not get the best because they will not pay for it and are too self-satisfied to know how to get it. Again and again it is pointed out how the movement fails to attract and keep the best brains."

These criticisms give a fair idea of the working out of the coöperative idea in Great Britain where the movement is long out of the experimental stage. It has been in existence in England about a century and today has seven and a half million members. Its finances are estimated at \$900,000,000.

Carry the coöperative idea into medicine as publicized by the Ann Arbor proponent and what guarantee have the coöperative families that the result will be any different from the experience of Great Britain.

The commodity one purchases is just worth about what one pays for it, or less, unless supplied gratis. Bargains are few and far between, whether medical service or a pair of shoes. Besides, none of the proposed plans reaches the indigent, who will continue to be the care of the medical profession.

#### FEWER, NOT A GREATER NUMBER OF DOCTORS

EFFECTIVE organization produces efficiency and the tendency of efficiency is to dispense with man power. Socialism, or a socialistic state, represents the highest form of organization and control. Coöperative societies, while not the fruit of socialism in the true sense, are nevertheless socialistic, even though they are voluntary organizations. Our concern is regarding the subject of medical services on a coöperative plan. In some European countries, notably Norway, Sweden, and Denmark, such coöperative societies are beyond the experimental stage. We have been told that instead of fewer doctors, we would require a great many more doctors than are now practicing in the United States, were the United States to become a coöperative society on a large scale. The number of doctors per unit of population in the United States is

\*Consumers' Coöperation in Great Britain; An Examination of the British Coöperative Movement: by A. M. Carr-Saunders, P. Sargent Florence and Robert Peers. Allen and Unwin. Regarding this book the *Manchester Guardian* writes: "During the last few years, a committee of economists and educationalists has been engaged on an inquiry into the British coöperative movement. The inquiry has had the goodwill and assistance of the movement, and the results are presented today in a book that should earn the gratitude—when they get over the shock—of all co-operators. The work of writing the book fell to Professors P. Sargent Florence, R. Peers and A. M. Carr-Saunders, but they had many assistants among research students at various universities. The result is a book of over 550 pages covering all phases of the movement and certain to have wide influence." The complete review from which these sentences were taken will be found in the *Manchester Guardian* of Jan. 28, 1938.



approximately one to seven hundred. In those Scandinavian countries which have adopted a coöperative system, we would expect a greater number of doctors per unit of population than we have in the United States. As a matter of fact, the reverse is true. Holland has one doctor for 1,417 of the population, Norway has one doctor for 1,555 and Sweden has one doctor for 2,660 of the population. This is what we would expect inasmuch as no doctor outside of the coöperative society would have any decent opportunity to earn a livelihood. We were further told that a doctor in a coöperative society is so envied by those outside that there is a waiting list of the best qualified men for salaries ranging from \$2,000 to \$5,000 a year. Naturally the positions would be attractive at almost any salary if the coöperative society included all or most of those citizens who were able to finance themselves. We are not told what becomes of the indigent sick. Who renders them medical care? Is it the doctor who is outside of the coöperative unit? The medical profession have rendered medical care to the indigent sick not only in free clinics but in their private offices. There is a feeling that such persons are no longer a burden on the community, so that socially inclined persons turn their attention to those who are able to pay for ordinary medical care.

The medical profession is not blind or deaf to the growing tendency towards centralization whether it be state medicine or coöperative medicine. This tendency is apparent to all. We are not attempting to criticize so much as to get at the facts. So far as we can learn of any of the collective plans of practice, fewer rather than a greater number of physicians will be required.

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### STREET ACCIDENTS

THIS is an inexhaustible perennial subject for discussion. Furthermore, it is a medical subject involving both prevention and treatment. It is too much to expect that all accidents may be prevented by drastic rules and punishment. The human personality must be reckoned with. Many drivers are border line psychoneurotics; under ordinary conditions, they get by, but

in an emergency they fall short and accident results.

Last year 40,000 persons are reported to have been killed and more than a million injured. Road traffic has produced fatalities almost as numerous as war. To reduce the number of accidents by insisting on safety of cars, in nineteen states, automobiles are subject to rigid and periodic inspection which includes lights, horn, windshield wipers and rear view mirrors, brakes and tires, steering wheel, exhaust line, gasoline and ignition systems. This is to be commended; not only does it make for safety of the automobile itself, but the driver is made safety conscious.

This is pre-eminently an age of speed; it is also an age of distances which must be covered in the shortest possible time. Many refuse to heed the old maxim, that carries with it so much truth, "Don't hurry for you have no time to lose." Sixty miles an hour means eighty-eight feet a second. The reaction time of a normal person to an external stimulus, either hearing or seeing, is said to be about a fifth of a second. With some it is slower than this. In a fifth of a second, one has travelled about eighteen feet if his automobile is going at the rate of sixty miles an hour. How important it is then that the car be mechanically perfect! Not only this, but how important also that the driver know himself and take cognizance of his surroundings before he attempts such speed.

The drunken driver is a menace to road safety. Stiff fines and prison sentences should inspire in him a wholesome regard for the rights of others. The thoughtless driver, the driver with atrocious manners who has no regard for the rights of others, is also a nuisance; he makes hairpin turns on a busy street without signalling those behind him. He is met when he suddenly makes a left turn for a cross street in front of oncoming traffic, trusting to luck to make his destination without being struck. In war, such a spirit might be called heroic, for the "hero" would be taking chances with his own life only; in traffic it goes by another name, which would not look well in print.

Consideration for the other person and plain good manners would have saved a large number of the forty thousand slain on this continent last year.

## ROLLIN HOWARD STEVENS HONORED\*

"One of the most active and vigorous figures in the practice of American radiology today is that of Dr. Rollin Stevens who now has reached the age of three score years and ten prophetically signalized in Scripture writ and whose enthusiastic sedulous and forthright individuality, crystallized in the service of mankind and polished by the gentle contact of each passing year, continues to reflect from its many facets his faith in his work and in himself in the doing of it as well as the joy of fulfillment which the realization of his life's ideals has assured to him."

SO RUNS the opening paragraph of a tribute to Dr. Stevens by Dr. Percy Brown of Boston in *Radiology* for January. Those of us who have known Dr. Stevens as a fellow member of the Wayne County Medical Society, as well as special societies to which many of us belong, feel that Dr. Brown has not only expressed his own kindly feeling, but the attitude of all Dr. Stevens' numerous friends, both within as well as outside of the medical profession. A great many complimentary statements could be made about the doctor as a man and as a member of a pioneer specialty, for he has seen radiology grow almost from its infancy. However, in Detroit and Michigan, his work is too well known to require it. He has been a lifelong student and his interests have transcended his office. Dr. Stevens is well known nationally for his work, which is aimed to advance the standard of radiology both in the domain of treatment and diagnosis. He is one of the founders (and is still a member) of the American Board of Radiology, the purpose of which is to certify to the qualification of specialists in x-ray diagnosis and treatment.

Dr. Stevens is a prolific writer. His bibliography comprises fifty-five titles. Entering the specialty of radiology by the dermatological route, his contributions on radiotherapy comprise a majority of subjects of his pen. He has not only pioneered in radiotherapy, but he has interested himself particularly in the radiation treatment of malignancy.

A man with a cultural hobby (and Stevens has several) never really grows old. The doctor is even a specialist on mush-

rooms (we have never learned the botanical term for them), but the fact that he has attained his three score and ten is proof that he knows his subject. Dr. Brown's interesting sketch of Stevens presents a full page of pictures on the subject from boyhood showing the evolution of the doctor. With advancing age, he retains a heavy shock of hair; the only change is a silvering as the years are numbered; in no sense the glabrous dome commonly associated with wisdom. In this, Dr. Stevens is the exception. This is too bad, for

After all is said,  
There is nothing like a bare and shiny head.  
Age lends the graces that are sure to please,  
Folks want their doctors mouldy like their cheese.

## MENTAL HYGIENE

"This is the greatest error in the treatment of sickness, that there are physicians for the body and physicians for the soul, and yet the two are one and indivisible."

This statement was first made by Plato over two thousand years ago and it has been made in substance, if not the exact words, many times since. Yet there is an attitude among many of us who care for the sick, which maintains that the absence of organic disease justifies us in the belief that there is nothing much wrong with the patient. Of course, the first thing to do when confronted with the problem patient is to make a thorough physical and laboratory examination. If this examination is thorough enough, and in the end reveals no physical lesion, then the physician should go farther. Mental ailments are as real as (sometimes they may be more so than) physical ailments. Shakespeare once said, "There is nothing good or bad, but thinking makes it so." If thinking makes a lesion, real or apparent, severe, then must the physician do what he can to "minister to a mind diseased and pluck from the bosom a rooted sorrow."

The physician in general practice is the first line defense in warfare against disease. People who are sick seek his aid first. His viewpoint should include mental as well as physical aspects of disease, and he should be prepared to deal with milder cases which require mental hygienic rather than institutional treatment. Often his rôle as father confessor, as a sympathetic listener, is all

\*Dr. Stevens was tendered a complimentary dinner by the staff of Grace Hospital, Detroit, on January 29, 1938, in honor of his seventieth birthday. See February Journal, M.S.M.S., page 195.



that is required, and a mental catharsis may prove entirely salutary to the patient.

Conditions under which we live at the present time are trying. When men's lives are geared to the tempo of the machine age, something, somewhere, is apt to break. The field for mental hygiene, considering this fact and the fact of economic insecurity, is forever widening. If we may conclude as we began, the physician for the body and the physician for the soul should be one and the same person.

#### INSCRIPTION BY JOHN McCRAE

This inscription on the fly-leaf of the post mortem record book of the Montreal General Hospital for 1902-1903 was written by Dr. John McCrae who was pathologist there at that time. It passed unnoticed for over twenty-five years and was only recently discovered when the pages were separated. The inscription which was first published in the *Canadian Medical Association Journal*, April, 1937, reads thus:

"Here begynneth ye Booke of ye Deade,  
wherein is fayrely set foorth ye last state  
of four hundred and seventeen persones,  
tht have departed this lyfe; wherein be  
tabled diverse strainge and fearsome condicions  
tht have ledde to ye same final ende; God  
have them of his grace."

There follows a quotation:

"Our lyfe is but a Winter's Day.  
Some only breakfast, and away.  
Others to dinner stay, and are fulle fedde.  
The oldest man but suppes, and goes to bedde,  
Large is this dette, yt lingers out the day.  
He that goes soonest, hath the least to pay!"

From *Horae Succisivae*

By Joseph Henshaw, Bishop of Peterboro, 1661.

The editor is indebted to Dr. W. H. Marshall of Flint for this interesting verse.

#### STATE MEDICINE IN MICHIGAN

"Physicians interested in obtaining positions in Michigan state hospitals and institutions are invited to compete in an open examination March 19 by the Michigan Civil Service Department. Residence requirements have been waived and all qualified citizens of the United States are eligible. Examination centers will be established in Michigan and in cities throughout the United States wherever there are sufficient applicants. The examination is being given to establish an eligible register from which names will be certified to fill present vacancies in the state hospitals. It is open to physicians not over thirty-five years of age who have been graduated from a medical school of recognized standing, who have a license to practice in Michigan or a license from a state with a reciprocating license agreement, and who have had one year of rotating internship in an approved general hospital. The tentative salary for the positions has been set at \$180 per month with certain deductions for maintenance.—From a news item in the *Journal A.M.A.*



## The Editor's Easy Chair

### USEFULNESS OF USELESS KNOWLEDGE

THE tendency of education for a number of years is to fit young people for the task of earning a livelihood or of earning a better livelihood than would be possible without it. This is, in a sense, commendable. Often statistics are pressed into service, the purpose of which is to show that persons with a high school education can command a higher salary than those without it; and that those with a college education are better paid, by and large, than those who enter upon a life work with a high school education. Such are the inducements held out to young people to pursue higher learning. Considering the plethoric conditions of high schools and colleges, statistical propaganda have been successful. This idea of education is not new. Thomas Carlyle, the English sage of the last century, deplored the idea prevalent in his time to the effect that parents wanted to know what education was best fitted to enable their sons to "drive a gig." This seemed to be the chief desire of the days when most people walked. John Ruskin, a contemporary of Carlyle, regretted the tendency on the part of parents to seek for their sons and daughters that particular education which would enable them to ring the front door bell of the houses of the great rather than the bell to the servants' entrance.

In other words, emphasis was and still is placed upon an education that would enable one to earn a living, rather than that which would enable one to live a life of fullness.

Those of us who are familiar with Conan Doyle's works, will recall that Dr. Watson took inventory of the knowledge of Sherlock Holmes and found that Sherlock Holmes was very proficient in those branches of erudition such as chemistry and geography which helped him as a detective, but his mind was blank on all that did not minister to his immediate occupation. Dr.

Watson endeavored to supply the deficiency by giving information on those subjects in which the great detective was weak or wholly wanting, only to be met with the reply that, "Now that I know these things, I shall immediately proceed to forget them."

There is a kind of knowledge that is wholly unnecessary for earning a livelihood, that is, very helpful in the art of living well. We will call it useless knowledge so far as the acquisition of an income is concerned. A physician, for instance, will find the subjects included in the medical curriculum of immense value to him in the practice of his profession. Music, literature and art for him fall into the category of useless knowledge. The musician, artist and writer would place the subject of pathology or anatomy in the same category, and yet there are probably few things more satisfactory to the doctor in his off moments than an appreciation of music, literature, or art, or any one of them; likewise the artist, the musician and the literateur might delve into physiology or anatomy to their personal advantage. The mind cannot rest or one's mental powers become renewed by mere passivity. Some select golf and other sports. Some pursue a hobby of some sort, useless so far as making a living, but very useful so far as giving satisfaction in life is concerned. Useful knowledge is a necessity; useless knowledge a privilege.

Someone has defined that elusive thing called culture as knowledge outside or apart from one's regular vocation. In other words, a knowledge or appreciation of art or literature would make a doctor a cultured man, or a fairly accurate, though not necessarily extensive, knowledge of physiology or anatomy would entitle the artist or musician to the same reputation. In other words, culture is defined as an acquaintance with departments of knowledge outside of one's vocational studies. There is an idea worth pondering over in this, though we do not offer it as the best definition of culture.

A great many of the leading physicians are fully cognizant of the importance of this so-called useless knowledge. Among them we might mention Osler, Weir Mitchell, and Oliver Wendell Holmes. Many other physicians have actually won renown

in fields apart from medicine. Their work is described in a fascinating little volume on the subject, *Medical Truants*. So-called useless knowledge has been appreciated by many of our profession whose names are not recorded on the Bede roll of fame.

The Ancient Greeks claimed that one must live before he could live well. The cultured Athenian had a system of slavery whereby the helots or Greek slaves performed the menial tasks so that the masters might devote themselves to those pleasures of the mind such as philosophy, art and rhetoric, which meant living well. Many moderns spend so much of their time in living that they forget the real object for which they are working, namely, to live well by enjoying the cultural opportunities that may be had for so little effort. They are interested in the acquisition of things rather than in pursuits that provide so much satisfaction. The word amateur, which ordinarily carries with it the idea of novice, and therefore inexperience, has a much different meaning. The amateur is one who does things entirely for the love of it (recall your Latin).

We have used the word "physician." Any other profession, law, engineering or teaching might be substituted. To any of these, so-called useless knowledge would be that which does not minister to their immediate calling. The writer knew a retired banker whose hobby was English and American history which he had mastered in the minutest detail. Though he attained his four score years, he never seemed to be an old man. "Age could not wither nor custom stale." Hobbies of various kinds may be listed in this class. It is not necessary, however, to argue with the hobbyist as to the value of the mental effort he devotes to those things which are outside of his means of earning a livelihood.

**Acquiring Fluency**—Jones: "How is your son getting on at college?"

Smith: "He must be doing pretty well in languages. I just paid for three courses—\$10 for Latin, \$10 for Greek, and \$100 for Scotch."—*Empire Review*.

**Crushed**—"Don't you think she looks smart in that dress?"

"Yes, but her hat looks as if it had made a forced landing."—*Halifax Chronicle*.



## POSTGRADUATE PROGRAM FOR 1938

Michigan State Medical Society—University of Michigan—Wayne University

The Department of Postgraduate Medicine of the University of Michigan Medical School, in conjunction with the Wayne University College of Medicine and the Michigan State Medical Society, announces the following short, intensive postgraduate courses:

### Annual Spring Courses

Ann Arbor

University Hospital

Electrocardiographic Diagnosis	April 4-9
Ophthalmology and Otolaryngology	April 25-30
Diseases of Metabolism	May 16-18
Diseases of Blood and Blood-Forming Organs	May 18-20
Roentgenology	June 27-Aug. 5
Pathology (four courses of two weeks in special subjects)	June 27-Aug. 19
Laboratory Technic	June 27-Aug. 19
Summer Session Courses	June 27-Aug. 19

Detroit

Pediatrics (Henry Ford, Children's and Herman Kiefer Hospitals)	April 18, 19 and 20
General Medicine (Receiving and Herman Kiefer Hospitals)	April 18-22
Proctology (Receiving Hospital)	April 25, 26 and 27
Urology (Receiving Hospital)	April 28, 29 and 30
Obstetrics, Gynecology and Gynecological Pathology (Receiving and Herman Kiefer Hospitals)	May 2-6

Consult Your Bulletin for Details.

### Annual Autumn Courses

The following subjects will be presented in the autumn Extramural Courses:

#### Gynecology and Obstetrics

1. The management of hemorrhage in pregnancy.
2. Evaluation of methods of management of pelvic inflammatory disease.

#### Surgery

3. Demonstration of the treatment of varicose veins and ulcers of the leg. The early and late cases.
4. Care of fractures of long bones.
5. Abnormalities and diseases of male genital tract.

#### Internal Medicine

6. The differential diagnosis of persistent cough.
7. Methods for diagnosing fever of unknown origin.
8. The prognostic significance of the white blood cells in infections.
9. A rational classification of nephritis and principles in management of the nephrides.

10. The significance of the cardiac arrhythmias.
11. A demonstration of the newer important laboratory aids for office use.
12. The criteria for the diagnosis of tuberculosis.

#### Neurology and Psychiatry

13. The care of the aged person.
14. The importance of early recognition of mental disease. The physician's rôle in the statewide program for control of mental disease.

#### Dermatology and Syphilology

15. The newer methods of treatment of some common skin diseases.
16. Evaluation of the Kahn test in treatment of syphilis. Management of latent syphilis.

#### Pharmacology

17. The indications for use of certain drugs.

#### Centers

Ann Arbor  
Battle Creek-Kalamazoo  
Bay City  
Flint

Grand Rapids  
Lansing-Jackson  
Marquette  
Traverse City-Manistee  
Cadillac-Petoskey

For further information, address:  
Department of Postgraduate Medicine  
University Hospital  
Ann Arbor, Michigan

# President's Page

## QUALITY MEDICAL SERVICE FOR ALL

I AM going to ask a blunt question: Is your county medical society well organized, doing things and accomplishing good for your community?

If it is organized, you already know the demands of the people, and how your county society and its individual members are trying to meet those demands. You recognize (1) that there is a demand for the continuation of high quality medical service, and (2) that this quality service must be made available and brought within the reach of all.

To a degree, the first demand may be met in a county having fair medical organization, because of the training, education and initiative of the individual practitioner of medicine; but no programs for the maximum distribution of medical service, especially in the newer field of preventive medicine, can be accomplished without the help of a very efficient medical society.

Service to the people implies that every county medical society knows the situation in its county with reference to curative and preventive medicine. This includes the major premise that the practitioners are well acquainted with the latest technics, including preventive medicine procedures, and that there is no medical problem in the community in which your county medical society does not accept leadership: who are better qualified to handle these technical matters than those trained in this particular field?

The layman today is giving a great deal of thought to the question as to whether everyone can obtain, or does obtain, medical service under our present system of practice. I am somewhat concerned at the approach the layman may make: that he may forget quality or may put price foremost, or may forget the value of properly trained practitioners. This indicates the imperative need for accurate and authentic information to the people, supplied by the county medical society.

Every county medical society should sit down calmly and honestly ask itself: "Are the people in this county able, under all conditions, to obtain medical services they need? If not, why?" If any lack is only partially our responsibility, I believe we should meet with all others concerned and discuss the problem. But leadership in medicine is the responsibility of medical practitioners and of their medical societies.

Our present system of private practice, based on the family physician-patient relationship, will be continued when we have done the best job possible in the distribution of the proper quality of medical service.

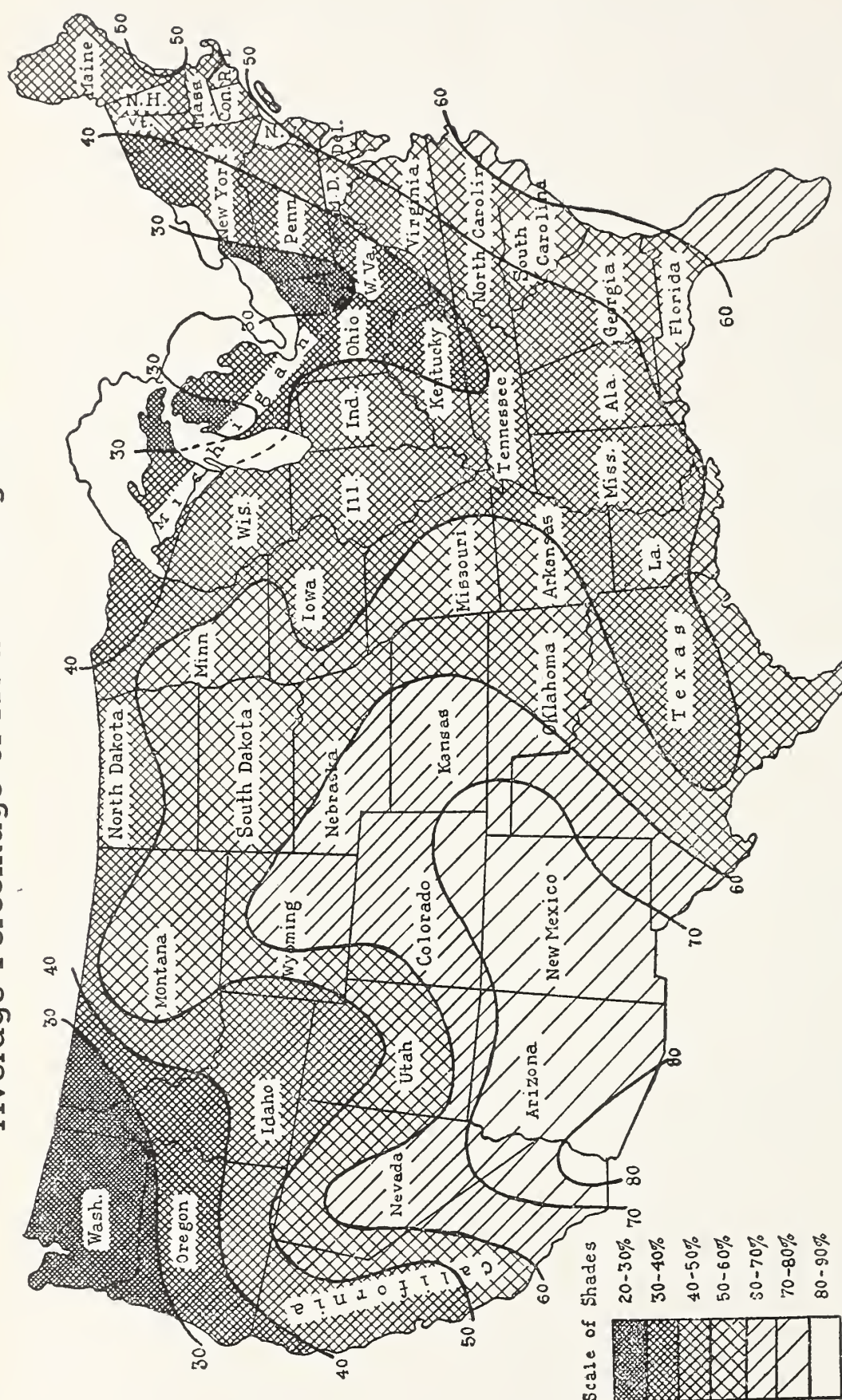
Respectfully submitted,



President, Michigan State Medical Society.



# Average Percentage of Actual Sunlight in Winter

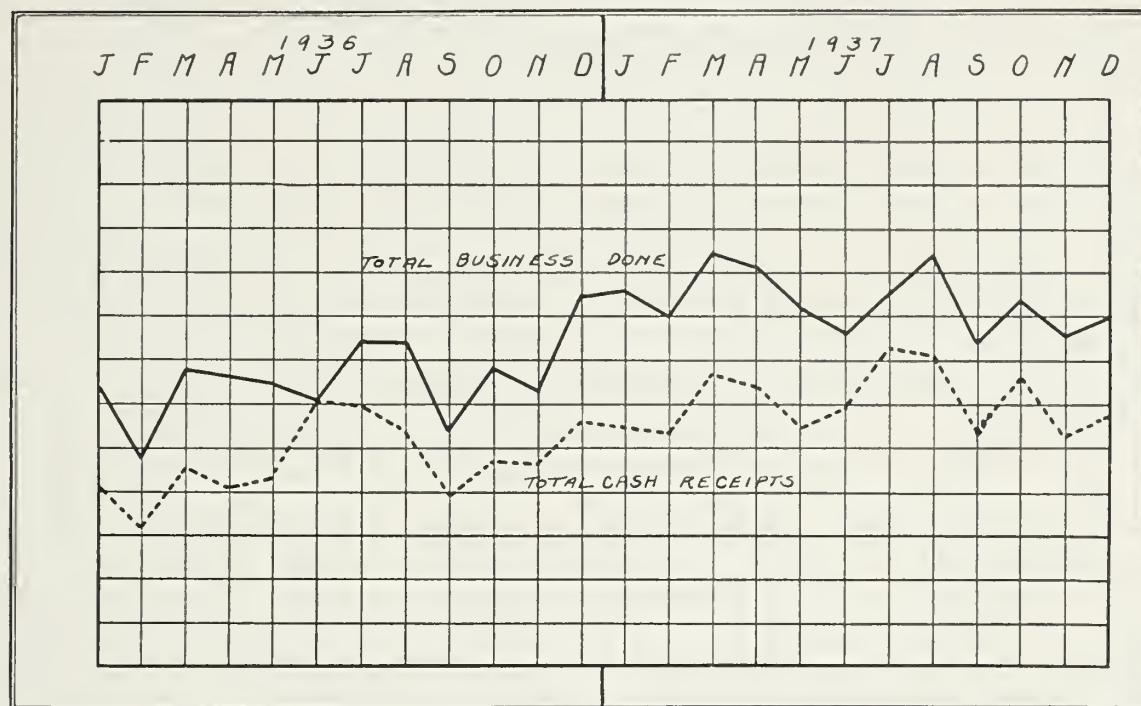


## WHY PEOPLE GO SOUTH IN THE WINTER

An increasing number of people are availing themselves of a short winter rest period in the south with considerable benefit to their physical and mental health. The average amount of sunshine per month during January, February and March in this area is approximately 140 hours, whereas in the nation's principal winter vacation spots, the average is 225 hours.

About 70 per cent of the nation's population, largely urban, reside in an area constituting approximately two-thirds of the country and lying north of a line drawn through the southern boundaries of an adequate intake of vitamins A and D. Natola is effective and economical.

This map, adapted from one prepared by the Michigan Department of Health, is reproduced from the Monthly Bulletin of the Indiana Division of Public Health, by permission of Dr. Thurman B. Rice, Editor. Electro contributed through the courtesy of "Therapeutic Notes" (Parke-Davis & Co., Detroit).



## "HOW'S BUSINESS?"

By HENRY C. BLACK and ALLISON E. SKAGGS

WHILE no amounts are shown in the graph, each straight cross line represents \$100.00. From the monthly figures of well over one hundred Michigan doctors, fifty were selected whose practices were most representative in their community, and the above is a graph by months of business done and cash received, based on this average. These practices include general practitioners and nearly all types of specialization, and are located in various parts of lower Michigan in communities ranging from the largest cities to the smallest villages. It might be interesting to note here that the size of the community seems to have little effect on the size of the income of the physicians practicing in it.

The solid line in the graph is average business done each month and includes only charges made for services whether paid for or not. The dotted line represents the average cash receipts for services each month, whether cash business or cash received on accounts.

Although the scope of the figures avail-

able to us does not allow us to draw the conclusion that these are average trends, at the same time we do feel that they represent a fair cross section of the experience of physicians who handle the business side of their practice well. The compilation of these figures was prompted by the varying comments of physicians who frequently remark that, say December, is always a bad month for them; or that collections are particularly good, say in the fall when crops are harvested. Also it was thought that while the effects of the current business recession are being described in relation to other business, the professional man might be interested in comparing his own experiences with a cross section of others in the same region.

We are making no attempt to draw any conclusions from these figures, but rather will point out several interesting facts which exist in the averages obtained for this two-year period:

(1) The month having the highest cash receipts in both years was July, and the lowest February.

(2) December Business and Cash exceeded November's in both years.

(3) Business fell off continuously from

(Continued on Page 273)



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## PRESS RELATIONS KENT COUNTY PLAN

IN order that there may be better public relations and a better understanding of medical problems in the minds of the public it is very evident that there must be developed between the county component units and the local press a definite set-up of press relations. This has become so apparent that in the larger metropolitan districts the press has appointed science writers to handle questions of a medical and scientific character. It has recently been said, "Medicine is the only profession that is muzzled." The so-called muzzling of the profession has arisen as the result of the Medical Code of Ethics and the reluctance on the part of organized medicine to so publicize its business that it might be interpreted as personal advertising.

There has developed in recent years a very decided demand on the part of the public for more information on matters of medicine and general scientific subjects. Unfortunately, much of the health information that the public has received has emanated from sources other than those of a medical character. It therefore behooves the medical profession to develop a definite press relationship so that the education of the public can be placed on a definite scientific basis. In other words, it is necessary for medicine to interpret itself to the public. The National Association of Science Writers has declared itself in favor of going directly to official committees of County Medical Societies for its information, in order that it may expect accurate authentic information from these groups. It is definitely understood, however, that all such information should be credited to County Medical Societies and not to any individual.

In order to apply in Michigan the principle of better press relations there is being developed in Grand Rapids what is known as the Kenty County Plan. This plan was inaugurated by conferences between representatives of the Kent County Medical Society and the various publications in the county. By a mutual agreement the various Press Associations have decided to contact this committee of the Kent County Medical

Society for any information on matters of medicine and health. By conferring with especially designated members of the Kent County Medical Society, it is very evident that the press of Grand Rapids and Kent County will have authentic information on all matters

### *The Directory Number May, 1938, Issue*

A list of all members of the Michigan State Medical Society (in good standing as of April 1, 1938) will be published in the May, 1938, JOURNAL.

pertaining to medicine and to the general public health of the community.

When the details of this plan and its mechanics for operation have been thoroughly worked out, it is hoped that the Michigan State Medical Society can, through its various component county units, apply the same principle of press and public relations to every community in Michigan. The success of the plan depends, first, upon a co-operative understanding between representatives of the press and those of organized medicine; secondly, there must be developed a very true sense of confidence on the part of both the press and representatives of the medical profession. This understanding and confidence entails on the part of the medical profession a frank discussion of those scientific and health problems that affect the general public; on the part of the press it entails a willingness to determine by conference what facts are of public interest as news items and what facts have no definite bearing on the general health of the community.

With the modern scientifically trained physician and the development of an in-

formed public on matters of health and scientific medicine, certain marked improvements are certain to result in both the type of medical care rendered to the people and an appreciation on the part of the public as to what constitutes good medical service and public health.

### STUDY OF MEDICAL CARE BY COUNTY SOCIETIES

THE American Medical Association has taken the leadership in encouraging county medical societies of the United States to undertake studies to determine medical needs and to formulate preferable procedures to supply these needs in accordance with established policies and local conditions.

Each of the fifty-four county medical societies in this state, component parts of the Michigan State Medical Society, has been approached to make this important survey, to determine the need, and to supply to the public all necessary medical and health facilities.

The importance of this plan is that the county medical society is asked to assume leadership in its respective jurisdiction.

The outline of this proposed plan for study of medical care is published in the *A.M.A. Journal* of February 12 (page 77 of the Organization Section). An outline of suggestions entitled "Study and Provision of Medical Care" has been sent by the Michigan State Medical Society to every president and secretary of our fifty-four county societies, covering the eighty-three counties of Michigan. The Councilors and Officers of the Michigan State Medical Society urge each county organization to proceed with this important work at once and to carry on until the job is completed. Any and all help will be supplied by the Executive Office of the Michigan State Medical Society, but the important work must be done locally by the county medical society which recognizes and appreciates special problems in each particular jurisdiction.

The Bureau of Medical Economics of the A.M.A. has prepared blank forms to aid county societies in these investigations. These blanks have been distributed by the Michigan State Medical Society.

Throughout the study, the three economic groupings of the people must be taken

into consideration: first, the economically comfortable; second, the employed of modest income; third, the unemployed (a) on the welfare; (b) not on welfare.

In "Study and Provision of Medical Care," attention is particularly directed to Section VI entitled "General Consideration," which states in part: "The process of collecting information requires much more than simply 'Yes' and 'No' answers to some leading questions." Most of the desired data will require a search of records to obtain accurate, dependable information.

To the officers of our fifty-four component county medical societies: we urge your coöperation and extreme interest in this study because it will (1) be beneficial to the public; (2) be of value to the individual practitioner; and (3) aid the prestige of the Michigan State Medical Society and its component county societies, already noted for efficiency and medical leadership.

### WHAT IS A SOCIAL WORKER?

SOCIOLOGY, or the study of the social sciences, is relatively a new profession in the field of human activity. Social workers have a great deal in common with the true physician, in that they deal mostly in human misery, just as has been the experience of Doctors of Medicine for centuries. Many of their objectives are the same as those of medicine, namely: the restoring to usefulness of unfortunate members of society who have become public charges, and the prevention of others from becoming so—through counsel and guidance. Worthy objectives such as these should be aided by the medical profession wherever possible.

Social workers as a whole represent an earnest, hard-working group. They are just as interested in the furtherance of good medical care for all as any practitioner of medicine. It would appear that the problem of medical service has been approached, in the past, by the medical profession from the scientific standpoint, in that we demand for the people a high quality of medical service; the social worker group approaches it from the standpoint of the distribution of medical service. The coördination of these two aims, and a closer understanding of the sociologists' viewpoint should result in benefit to all. Viewed in the light of reason,



sans emotion, both groups in these quasi-public services—the doctors of medicine and the social workers—are seeking after the same solution of present-day medical problems. Together, these two groups can work out a plan that may lead the way to a better medical policy for medical care of the indigent, including all classifications. Proof that it can be done generally is given in certain county medical societies of this and other states, where good coöperation has been accomplished—to the benefit of the people in general.

### NORTHWEST REGIONAL CONFERENCE

THE 1938 Northwest Regional Conference was held at the Palmer House, Chicago, February 13. Members of sixteen middlewest State Medical Societies comprise the membership of the Conference. Deliberations of the Conference, held annually, are devoted to consideration of the economic and social aspects of sickness. General subject of the Conference was "Medical Care for All the People." Specific subjects bearing on the general Conference theme were, "Preventive Medical Care," "Rehabilitation of the Indigent," "Group Hospitalization," and "General Medical Relief." Medical care for all the people was discussed from the standpoint of the American Medical Association, the State Medical Societies and the County Medical Societies.

The Indiana State Medical Society acted as host to the Conference. The sessions were presided over by its president, R. L. Sensenich, M.D., South Bend, Ind. Among the 200 in attendance at the sessions were President Henry Cook, M.D., Secretary L. Fernald Foster, M.D., and Executive Secretary Wm. J. Burns of the Michigan State Medical Society, R. G. Tuck, M.D., Pontiac, Mich., and J. A. Bechtel, Executive Secretary of the Wayne County Medical Society. Dr. R. G. Tuck presented the Oakland County Medical Relief Plan. Dr. Cook, Mr. Burns and Mr. Bechtel participated in the various discussions.

The Missouri State Medical Society will act as host to the Conference in 1939. The officers elected for that year are: Carl F. Vohs, M.D., St. Louis, Mo., president, and L. Fernald Foster, M.D., Bay City, Mich., secretary.

### COUNCIL AND COMMITTEE MEETINGS

1. Thursday, January 20, 1938—Mental Hygiene Committee—W.C.M.S. Building, Detroit—5:00 p.m.
2. Saturday, January 22, 1938—Public Relations Committee—Hotel Olds, Lansing—6:30 p.m.
3. Wednesday, February 9, 1938—Executive Committee of The Council—Hotel Pantlind, Grand Rapids—1:00 p.m.
4. Tuesday, February 15, 1938—Contact Committee to Governmental Agencies—Hotel Olds, Lansing—5:30 p.m.
5. Sunday, February 20, 1938—Committee on Scientific Work—Hotel Olds, Lansing—3:00 p.m.

## COMMUNICATION

### MORE ON THE BRITISH MEDICAL (PANEL) SYSTEM

To the Editor JOURNAL of the Michigan State Medical Society:

"Truth crushed to earth shall rise again," so said the poet; and, I suppose, will continue to arise in spite of being labelled "sub-service."

The starting exposé of the British Medical System, made by Dr. D. W. Orr in the past three issues of *Survey Graphic* should be read and understood by all general practitioners of medicine in this good old U. S. A.

It would seem that Dr. Orr lived at Toynbee Hall (London's Hull-House), and had access to the insured laborers themselves, and to the medical men who work in the System, taking care of these workers.

I speak of laborers because, at the present time, only those with an income of less than \$1,250 per year *must* come under the act, and a wife or other dependents are left free to choose any doctor that they can pay privately.

But the worker also has a free choice of doctors; we have been fed the idea that among doctors only the "failure," or the "poor mixer" willingly worked in the System. However, the truth of the matter is that the workers have to select one out of 19,000 British general practitioners who are anxious for the work; further, he can change doctors any time he likes without any questioning; if he complains at treatment received the poor doctor is investigated by a committee of his confreres; in London with *two million* insured and *two thousand* doctors taking care of them, only thirty-four complaints were filed in 1936; and what does *that* record do to the tale that only "failure" doctors come into the System!

A doctor's panel may not be larger than 2,500 insured; the average is considerably less. Suppose you had a panel of 1,500 at \$2.25 per year—\$3,375.00 payable quarterly—that must include upward of 5,000 dependents for private pickings, wouldn't you feel that you were sitting pretty? Why these doctors make up to \$12,000 per year without "surgical fees" and *without worry*.

In conclusion, it would seem that the British public and doctors are disgustingly well satisfied with this "Communitistic" scheme and are very deliberately working for its spread over all dependents, and to include those with incomes up to \$2,000 per year.

C. C. PROBERT, M.D.

Flint, February 14, 1938.

# MID-WINTER MEETING OF THE COUNCIL

January 12 and 13, 1938

## HIGHLIGHTS:

1. Annual Meeting, Detroit, September 20, 21, 22, 1938, to feature 30 eminent guest lecturers in seven general assemblies.
2. Secretary, Treasurer, Editor, Medico-Legal Committee, Executive Secretary elected.
3. Budget for 1938 approved.
4. The principle of the Michigan Health League's constitution and by-laws approved.
5. Brochure, conclusively proving that preventive medical procedures—by the early treatment of tuberculosis, syphilis, etc.—will save money in the long run by cutting down long-time institutional care, authorized for publication and distribution to township, city, county, and state officials.
6. Reports of twenty-one committees show amazing activity in behalf of better medical care and its distribution in Michigan.
7. Survey of Medical Relief cases by M.S.M.S. Committee on Distribution of Medical Care authorized.
8. All county medical societies are urged to continue their filter systems and work in connection with the Afflicted Child Law.

## First Session of the Council

1. *Roll Call.*—The Mid-winter Meeting of The Council was called to order in the Judge Woodward Room of the Statler Hotel, Detroit, at 10:20 a.m. All Councilors were present except Dr. W. A. Manthei, who telegraphed he was unable to attend. Also present were Drs. Henry Cook, Henry A. Luce, L. Fernald Foster, Wm. A. Hyland, J. H. Dempster, Wm. J. Stapleton, Jr., J. M. Robb, G. C. Penberthy, Executive Secretary Wm. J. Burns, and Lynn Leet of the Executive Office.

2. *Minutes.*—The minutes of the meeting of December 12 were presented, read and approved.

3. *Secretary's Annual Report.*—Presented by Secretary L. Fernald Foster as follows:

## SECRETARY'S ANNUAL REPORT—1937

I herewith submit the report of the Secretary for 1937.

The year 1937 marked another twelve months of constructive activity by the Michigan State Medical Society, in the interests of the medical profession and the people of this state. The Society continued the ambitious program laid out in former years, and blazed new trails in scientific, sociologic, and political areas.

## Membership

The total membership for 1937 was 3,963 with dues of \$38,953.50 accruing to the Society. The number of unpaid dues in 1937 was 144. The membership tabulation for the years 1936 and 1937 showing net gains and losses, unpaid dues and deaths is as follows:

1936	1937	Gain	Unpaid	Deaths
3,725	3,963	238	144	38

Of approximately fifty-five hundred physicians in Michigan, it is estimated that the maximum potential membership of the Michigan State Medical Society could be 4,725. This represents physicians in the active practice of medicine. Therefore, there are at most no more than 700 physicians in Michigan now eligible for membership in the Michigan State Medical Society.

In 1937 an appreciation of the benefits of membership, due to increased activities of the State Society, interested 238 additional physicians to affiliate with organized medicine. With the appoint-

ment of the new Membership Committee, and the augmenting of advantages of membership in the Society, I would estimate that the Michigan State Medical Society membership in 1938 should be 4,300.

## MEMBERSHIP RECORD

	1936	1937	Loss	Gain	Unpaid	Deaths
Allegan .....		22	—	22	3	—
Alpena-Alcona-Presque Isle ..	13	18	—	5	—	—
Barry .....	15	15	—	—	1	—
Bay-Arenac-Iosco-Gladwin ....	69	71	—	2	2	1
Berrien .....	51	45	6	—	8	2
Branch .....	22	23	—	1	—	—
Calhoun .....	118	119	—	1	2	1
Cass .....	12	16	—	4	—	—
Chippewa-Mackinac .....	20	23	—	3	2	—
Clinton .....	11	11	—	—	—	—
Delta .....	18	20	—	2	1	—
Dickinson-Iron .....	21	23	—	2	1	1
Eaton .....	27	29	—	2	—	3
Genesee .....	153	155	—	2	7	—
Gogebic .....	27	26	1	—	—	—
Grand Traverse-Leelanau-Benzie	31	33	—	2	1	1
Gratiot-Isabella-Clare .....	33	35	—	2	1	—
Hillsdale .....	27	26	1	—	2	—
Houghton-Baraga-Keweenaw ..	34	38	—	4	1	—
Huron-Sanilac .....	25	29	—	4	1	—
Ingham .....	128	134	—	6	—	—
Ionia-Montcalm .....	33	38	—	5	—	—
Jackson .....	86	91	—	5	—	—
Kalamazoo-Van Buren .....	134	126	8	—	2	2
Kent .....	220	227	—	7	11	3
Lapeer .....	13	16	—	3	—	—
Lenawee .....	41	40	1	—	—	1
Livingston .....	17	19	—	2	—	1
Luce .....	12	13	—	1	—	—
Macomb .....	34	39	—	5	1	—
Manistee .....	14	16	—	2	—	—
Marquette-Alger .....	35	35	—	—	—	1
Mason .....	7	10	—	3	—	—
Mecosta-Osceola .....	19	17	2	—	1	1
Menominee .....	12	17	—	5	—	1
Midland .....	12	11	1	—	3	—
Monroe .....	36	37	—	1	2	1
Muskegon .....	70	77	—	7	—	1
Newago .....	10	10	—	—	—	1
Northern Michigan .....	28	31	—	3	—	—
(Antrim, Charlevoix, Emmet, Cheboygan)						
Oakland .....	114	125	—	11	5	1
Oceana .....	10	10	—	—	—	—
O.M.C.O.R.O. ....	13	14	—	1	1	—
(Otsego, Crawford, Oscoda, Montmorency, Roscommon, Ogemaw)						
Ontonagon .....	5	6	—	1	—	—
Ottawa .....	37	33	4	—	—	—
Saginaw .....	90	96	—	6	2	1
Schoolcraft .....	6	7	—	1	—	—
Shiawassee .....	29	33	—	4	—	1



# MID-WINTER MEETING OF THE COUNCIL

St. Clair	42	47	-	5	-	-
St. Joseph	12	15	-	3	-	1
Tuscola	31	32	-	1	-	1
Washtenaw	159	149	10	-	15	2
Wayne	1,471	1,592	-	121	65	9
Wexford	18	23	-	5	3	-
Kalkaska, Missaukee						
	3,725	3,963	34	272	144	38
		3,725		34		
		238		238		

## Deaths During 1937

During 1937 we regretfully record the deaths of the following members:

*Bay County*—Dr. Wm. G. Kelly, Bay City.  
*Berrien County*—Dr. Ernest W. Tonkin, Niles; Dr. Robert H. Snowden, Buchanan.  
*Calhoun County*—Dr. E. E. Hancock, Battle Creek.  
*Dickinson-Iron County*—Dr. Arthur Lempton Haight, Crystal Falls.  
*Eaton County*—Dr. W. L. McCormick, Bellevue; Dr. E. A. Schilz, Grand Ledge; Dr. E. A. Runyan, Linden.  
*Grand Traverse-Leelanau-Benzie*—Dr. A. S. Rowley (retired), Traverse City.  
*Kalamazoo County*—Dr. A. W. Crane, Kalamazoo; Dr. J. W. Hawkey (Emeritus Member), Bloomingdale.  
*Kent County*—Dr. Collins H. Johnston, Grand Rapids; Dr. Thos. O. Menees, Grand Rapids; Dr. Fred H. Shorts, Kent City.  
*Lenawee County*—Dr. Clarence H. Westgate, Morenci.  
*Livingston County*—Dr. C. L. Sigler, Pinckney.  
*Marquette-Alger County*—Dr. H. B. Markham, Marquette.  
*Mecosta County*—Dr. John L. Burkart, Big Rapids.  
*Menominee County*—Dr. J. K. Parish, Hermansville.  
*Monroe County*—Dr. H. T. Gray, Carleton.  
*Muskegon County*—Dr. Paul A. Quick (Honorary Member), Muskegon.  
*Newago County*—Dr. P. Drummond, Grant.  
*Oakland County*—Dr. Aileen B. Corbit, Oxford.  
*Saginaw County*—Dr. W. F. Morse, Saginaw.  
*St. Joseph County*—Dr. O. S. Behrentz, Three Rivers.  
*Shiawassee County*—Dr. Philip E. Marsh, Bancroft.  
*Tuscola County*—Dr. J. T. Redwine, Wahjamega.  
*Washtenaw County*—Dr. Helene Schultz, Ann Arbor; Dr. C. O. Woodbridge, Saline.  
*Wayne County*—Dr. Carl Bonning (Honorary Member), Detroit; Dr. Frederick B. Burke, Detroit; Dr. John L. Chester, Detroit; Dr. F. R. Olney, Detroit; Dr. Geo. E. Potter, Detroit; Dr. Martin J. Schwanz, Detroit; Dr. Robert F. Shinsky, Detroit; Dr. Alois Thuner (Emeritus Member), Point Loma, California; Dr. Albert B. Walker, Detroit.

## Financial Status

The fiscal year closed on December 24, 1937, and the statement of our certified public accountants, Ernst & Ernst (to be published in THE JOURNAL) shows the financial status as of that date. The following facts are noted:

1. The assets of the Society are \$32,282.00 as against those of \$40,345.00 in 1936. The net worth is shown as \$11,764.00, a reduction from \$19,738.00 a year ago.

The net loss incurred on the exchange of securities is \$2,457.00, \$2,218.93 of which is shown in the Medical Defense Fund. It would seem as though the present fixed assets of the Society indicate a better condition than before the exchanges were made, since the decrease in values was less than on the old assets.

2. The Medical Defense Fund shows a balance of \$12,048.60, this being a decrease of \$3,936.24. About 50% of this loss is represented by expenses over and above the funds allotted from the dues for Medical Defense purposes, the other 50% being sustained by the exchange of securities.
3. THE JOURNAL advertising sales in 1937 totaled \$9,548.11, practically the same as in 1936. The cost of printing THE JOURNAL in 1937 was \$9,965.04, as against \$9,593.73, this slight increase being due largely to the increased material costs. The net income of THE JOURNAL in 1937 was \$1,206.85, this however includes the allocation of funds for subscriptions from dues, this allocation amounting to \$5,842.93.
4. The report shows no balance in the funds of the Joint Committee on Health Education,

whose bookkeeping the Society has been doing.

Before the audit of the books the balance in this fund was turned over to the Joint Committee.

With the exchange of securities and an increase in dues in 1938 the financial structure will be in good shape. During the past year there was a decided increase in the activities of the Society and the financial statement would seem to be consistent with this activity.

## The 1937 Annual Meeting

Long-time members of the M.S.M.S., who have attended annual meetings for years, have advised me that the Grand Rapids Convention and Exhibition was the most remarkable and the best session in the history of the Michigan State Medical Society. The physician registration was 1,138. The program was developed to gain the interest and for the good of the general practitioner, who comprised the bulk of the registration. The general assembly type of program gave an opportunity to each registrant to hear all speakers, which in the aggregate provided a well-rounded Postgraduate Course. The doctors accorded the exhibitors generous attention and thereby created much goodwill for the benefit of the M.S.M.S. This was reflected in a substantial profit from the convention, despite the high cost of a greatly-augmented program with twenty-nine out-of-state speakers, and many extraordinary activities.

## County Secretaries' Conferences

Two County Secretaries' Conferences were held since the Mid-winter Meeting of the Council in January, 1937, one on February 7th in Lansing, and another on September 29th in Grand Rapids. The first Conference attracted 101, including 40 secretaries. The registration at the Conference held in conjunction with the Annual Meeting of the M.S.M.S. totaled 84, including 34 secretaries. The 1938 Annual Conference is scheduled for Lansing on Sunday, January 23rd. I anticipate that all attendance records will be broken, due to the excellence of the program and even greater interest in the State Society.

## Committees

The constantly expanding scientific, sociologic and economic importance of the medical practitioner is directly reflected in the work of his State Medical Society, which now requires twenty-five committees to aid physicians in their modern practice of medicine.

The scientific activities and accomplishments of the following committees are well known: Cancer Committee, Preventive Medicine Committee, Postgraduate Medical Education Committee, Maternal Health Committee, Mental Hygiene Committee, Occupational Disease Committee, Syphilis Control and Tuberculosis Control Committees, Radio Committee, Joint Committee on Health Education; the plans and programs of the sociologic groups have materially aided the medical profession and the public with the proper distribution of medical care in Michigan: the Committee on Distribution of Medical Care, Public Relations, Committee, Contact Committee to Governmental Agencies, Legislative Committee, Ethics Committee, Advisory Committee to Parole Commission, Committee on Health League, and Liaison Committees with the Hospital Association and with the State Bar of Michigan.

## Society Activity

In the past year, your two Secretaries have visited forty-four of the fifty-four component county medical societies, usually accompanied by members of the Council or officers or committee-men. We be-



lieve that the esprit de corps of the component societies is of the highest calibre at the present time. In addition, we note that county medical societies are following the suggestion of reelecting efficient secretaries, replacements being made this year in only six or seven units.

The Radio Committee has continued its progressive program of public education by weekly broadcasts for a period of twenty-four weeks (from November 1 to April 11) over ten Michigan stations. Much credit and thanks are due the Joint Committee on Health Education for its help and coöperation in this work, particularly to its field Secretary, Dr. Clare Gates.

The Speakers' Bureau of the Society provided 46 speakers for medical societies, upon request. In addition, it despatched twenty-four speakers to address lay groups in various parts of the State. This is a total of 70 speakers for the first year of the Bureau's operation.

The "Placement Service" of the Michigan State Medical Society was created in 1937, to help any Michigan community which may feel the need of a doctor of medicine, and also to assist young physicians about to enter practice, or older doctors, to find locations.

During the year fourteen Secretary's Letters were issued, nine to Secretaries of county medical societies and five to all members of the M.S.M.S. In addition numerous legislative bulletins were sent to the membership and to the secretaries of the societies.

It is interesting to note that 12 component societies are now publishing their own Bulletins.

## Recommendations

Your secretary concludes his report with the following recommendations, that:

1. A concerted membership drive be instituted during the months of February, March and April, 1938, and during the same period in subsequent years.

2. The ratio of reading matter and of advertising in THE JOURNAL approximate as closely as possible the 60%-40% basis.

3. In view of several requests for changes in Councilor and County Society districts, a study be made immediately of this important subject.

4. A definite program of press relations on the part of component county medical societies with their local press be instituted in all communities, in accordance with the State Society's plans and program.

5. The present type of Annual Meeting program—use of the General Assembly be maintained.

6. In the interest of economy, that the Public Relations Committee letters be made a part of the monthly Secretary's Letter.

Your Secretary wishes to take this opportunity to express his appreciation to this COUNCIL for its coöperation during the past year. It is a genuine pleasure to recognize the splendid interest and effort shown by all the Officers and Committees of the Michigan State Medical Society in their work. Too much commendation cannot be accorded Executive Secretary Burns and his office personnel for their untiring efforts in the interests of organized medicine. Mr. Burns has given unstintingly of himself in enthusiasm, constructive suggestions and coöperative effort at all times. He has been a real inspiration and aid to the Secretary in the discharge of his duties.

Respectfully submitted,

L. FERNALD FOSTER, M.D.,

Secretary

January 12, 1938.

MARCH, 1938

The report was referred to the County Societies Committee.

4. *Treasurer's Annual Report*.—Presented by Treasurer Wm. A. Hyland as follows:

## TREASURER'S REPORT—1937

As Treasurer of the Michigan State Medical Society, I wish to submit the following report for the year 1937.

As required by the by-laws of the Society, the usual indemnity bond was filed with the State Secretary.

The \$2,000 American Telephone and Telegraph Co. bonds, 5s, due 1960, which were called on January 1st, 1937 and as per authority set forth at the Meeting of the Executive Committee on November 11th, 1936, I obtained \$2,000 American Telephone and Telegraph 3¼ bonds due December 1st, 1966, for which I held Temporary Debentures without coupons at the time of the last Annual Treasurer's Report—January, 1937. These bonds were delivered to me in May, 1937.

The Executive Committee of the Council of the Michigan State Medical Society at its meeting of April 22nd, 1937, approved the motion that the Special Committee to Study Bonds (composed of Drs. Hyland, H. R. Carstens and V. M. Moore) be granted power to use its best judgment to dispose of the bonds of the Michigan State Medical Society as the committee sees fit, including all bonds not having an AAA rating.

As per the above authority, the following sales and purchases were executed during the past year.

Bonds Purchased			
\$7,500	U. S. Savings Bonds.....	7/ 1/47	75
1,000	Standard Oil Co. of New Jersey .....	3%	6/ 1/61 98
2,000	Consumers Power Co.....	3¼ %	11/ 1/66 100¼
2,000	Commercial Investment Trust.....	3½ %	7/ 1/51 102½
1,000	Dominion of Canada .....	3%	1/15/67 93¾
2,000	Detroit Edison Company.....	3½ %	9/ 1/66 108¾

Bonds Sold			
\$2,000	Community Power and Light.....	5%	3/1/57 73¾
3,000	Public Gas and Coke.....	5	12/1/52 42¼
5,000	G. R. Affiliated Corp.....	5	10/1/55 75
2,000	50 Lower Broadway Bldg.....	3	3/1/46 52
2,000	International Tel. & Tel.....	5	2/1/55 72
2,000	Herald Square Bldg.....	Inc.	5/1/48 47½
2,000	Peoples Light and Power.....	5½	7/1/41
2,000	American Tel. and Tel.....	5	2/1/65

Called 110

The following securities are now in my holding:

## General Fund

### Bonds

American Telephone & Telegraph Company .....	3¼ %	\$ 2,000.00
Associated Gas & Electric Corp. ....	4% inc.	2,000.00
Central Illinois Public Service Co.....	4½	2,000.00
Commercial Investment Trust Corp....	3½	2,000.00
Consumers Power Company.....	3¼	2,000.00
Grand Rapids Affiliated Corporation...	5	1,000.00
National Electric Power Company....	5	5,000.00
New England Gas & Electric Co.....	5	1,000.00
Standard Oil Company—New Jersey...	3	1,000.00
United Light & Power Company.....	5½	2,000.00
United States of America Savings Bonds .....		4,000.00
		\$24,000.00

## Medico-Legal Defense Fund

### Bonds

The Government of the Dominion of Canada .....	2½ %	\$ 1,000.00
The Government of the Dominion of Canada .....	3	1,000.00
Canadian Pacific Railway Co.....	4	2,000.00
Detroit Edison Company.....	3½	2,000.00
Grand Rapids Affiliated Corp.....	5	1,000.00
New England Gas & Electric Company .....	5	1,000.00
New York Central Railroad Co.....	4	2,000.00
Southern Pacific Company.....	4½	2,000.00
United States of America Savings Bonds .....		3,500.00

### Stock

National Gas & Electric Corporation—common—96 shares .....		960.00
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According to Ernst and Ernst, Auditors, our bonds were quoted at the time of their rating at \$28,978.00 valuation—that is, our present holdings. The valuation of our holdings of a year ago at this time would be \$25,000.00. In addition to the much better security, our present holdings have a valuation of over \$4,000.00 over our former list.

We have two holdings which are at present going through the process of re-organization under the bankruptcy act—namely, Associated Gas and Electric and National Electric Power Co. The holdings of the former being \$2,000 and \$5,000 in the National Electric Power Co.

Another holding, New England Gas and Electric, which totals \$2,000 is not classified by the First National Bank of Chicago—Bond Department or the Bond Department of the Manufacturer's Trust Co. as the type of security that should be on our list. However, although it is quoted at 56 by the auditors, there is no market for this bond at present, but we have kept a close scrutiny of the sales and I believe that disposal as soon as possible would be wise.

We have \$2,000 of the G. R. Affiliated Corp. remaining, having disposed of \$5,000 at 75—a much better figure than we expected to receive. This is a very closely owned corporation and there is very little call for these bonds. However, within the last few days I have been connected with a source from which I may receive a definite offer, though somewhat under the figure of 75.

In conclusion, at present I think our holdings are of the highest type of safety with a fair income. Although many of the bonds we disposed of were of the highest type when purchased, they became through the passage of time and economic disturbance of a rather inferior grade and I think the plan of disposing of them during the past year was very timely and greatly insured our safety.

I appreciate very much the advice and help of the Council and the many friends of the Michigan State Medical Society, particularly the Bond Departments of the First National Bank of Chicago and the Manufacturer's Trust Co. of New York as also the Grand Rapids Trust Co.

Respectfully submitted,

WILLIAM A. HYLAND,  
Treasurer.

\* \* \*

The report was referred to the Finance Committee.

5. *Editor's Annual Report*.—Presented by Editor James H. Dempster as follows:

#### THE EDITOR'S ANNUAL REPORT—1937

The editor's report this year marks a period of ten years as editor of this JOURNAL. It has been ten years of exacting but very interesting work. The associations during the past decade have been of great interest and importance to me. The men who have been elected to control the destiny of the Michigan State Medical Society during this time have shown an earnest zeal to work in the interests of the society as they conceived their duty. During the latter years of this decade, many problems have arisen for solution which were unknown in 1927 and 1928. It has been ten years of valuable friendships as well as a liberal education for myself. During this time, THE JOURNAL has grown so that the last volume (36, 1937) is the largest ever published by the Michigan State Medical Society. The object of the Council has been to make THE JOURNAL reflect in a very real sense each year the spirit and accomplishments of the society.

Under the department, County Society Activities,

every member has had the opportunity to follow from month to month the deliberations of the Executive Committee of the Council and twice a year the deliberations of the Council as a whole, and in November of each year a complete verbatim report of the deliberations of the governing body of the society, namely, the House of Delegates. Editorially, an attempt has been made to discuss the current movements in as fair and impartial a way as the editor is capable. We have sought a long range rather than an immediate view. An endeavor has been made to edit carefully all contributions. Sometimes it has been necessary to carry on correspondence with the author over some phases of the paper so that the finished JOURNAL does not by any means represent the entire duties of the editor. The Publications Committee have been consulted and the editor has endeavored to carry out faithfully the policy as agreed upon by the Publications Committee as representing the council. As large as THE JOURNAL has become, there is still a pressing demand for space. Many of the articles are long, almost entitled to be considered as monographs on the subjects discussed, and quite frequently letters are received from distant cities and towns in the United States for copies of our JOURNAL containing certain articles. This happens almost every week of the year.

The Woman's Auxiliary of the Michigan State Medical Society is very active and has been accorded ample space for their county society and other reports in THE JOURNAL. We feel that this is a forward step inasmuch as it brings the doctor's wife into close harmony with her husband's problems.

We have endeavored to include all medical news of general interest to all members of the society. This is of course an ideal that can be attained only through the coöperation of every member, whose help is asked to make THE JOURNAL as newsy and as interesting as possible.

All of which is respectfully submitted,

J. H. DEMPSTER.

\* \* \*

The report was referred to the Publications Committee.

6. *Annual Report of the Publications Committee*.—This report was presented by Dr. A. S. Brunk, Chairman:

#### REPORT OF PUBLICATIONS COMMITTEE

You have heard the report of the editor to the effect that the last volume, that is, volume 36 for the year 1937, is the largest yet gotten out by the society. The exact number of pages is 1,014 for the entire year. This number is increased by the fact that a number of columns of printed matter have been run through the advertising pages at the end of THE JOURNAL.

Your attention is called to the quality of THE JOURNAL, including the materials in the way of paper on which it is printed.

We believe it is generally conceded that THE JOURNAL is highly satisfactory as a publication. The articles are well displayed, the typographical arrangement is all that could be desired and the scientific papers, as well as other reading matter, are as free from typographical errors as it is possible to have them.

The editor calls our attention to the demand on the part of writers for space in THE JOURNAL. One object of your committee has been to give THE JOURNAL as wide an appeal as possible. By this, we mean only scientific papers, which have a wide appeal, are accepted rather than technical

JOUR. M.S.M.S.



papers, the space of which is in specialist journals.

As is well known, for many years a dollar and a half has been earmarked from each member's annual dues towards the publication of *THE JOURNAL*. This is the direct cost to each member of the society. He pays nothing more, though all must admit that *THE JOURNAL* is worth a great deal more, since it comes to each one's desk as a monthly postgraduate course. The major cost of publication is met through advertising. Mr. Burns has made a survey of the income from advertising and costs over a period of approximately three years—to be exact, thirty-four months. The average monthly income from advertising during this period was \$767.63. The average cost of printing during this period was \$898.85. If the publication of *THE JOURNAL* depended entirely on the advertising, it would be seen that the difference between these two sums indicates a loss. Efforts, however, have been made to cover this loss, by an increased advertising. These efforts have been partially successful, but owing to the increased costs of printing, particularly during the past year, the net receipts from advertising alone have not met the increased cost of publication.

Of course, added to the advertising is the dollar and a half per member which, on a basis of 3,500 members, a conservative estimate, the income from membership dues has been \$5,250. This sum has taken care of the increased cost of publication so far, together with the editor's salary, and has left a margin to the good. According to Mr. Burns, "In a strict business sense, relying exclusively on the income from advertising, *THE JOURNAL* loses money each year and will continue to do so until we either secure more advertising or cut down on the number of pages devoted to reading matter." Of course, no lay publication depends entirely on advertising for its revenue. The annual subscription, which would correspond in our case to the dollar and a half per member, is a considerable sum towards defraying the expenses of publication; even the three cent daily price of the newspaper is a valuable contribution to the expense of the publication of newspapers. It is needless to say that your committee heartily endorses the efforts of the Executive Secretary to increase the amount of advertising in *THE JOURNAL*.

All of which is respectfully submitted.

A. S. BRUNK, M.D., *Chairman*,  
ROY H. HOLMES, M.D.  
T. F. HEAVENRICH, M.D.  
F. T. ANDREWS, M.D.  
J. E. MCINTYRE, M.D.

\* \* \*

7. *Annual Report of Medico-Legal Committee.*—Presented by Dr. W. J. Stapleton, as follows:

#### REPORT OF THE MEDICO-LEGAL COMMITTEE—1937

Herein is the annual report of the Medico-Legal Committee of the Michigan State Medical Society for the year 1937.

Thanks are due the committee members for their coöperation. A special word of thanks is due the Chairman—Doctor Angus McLean—for his constant help in the work of the Committee. Our thanks are also due the attorneys for the Society—Messrs. Barbour and Purdy. They are at all times ready to aid in answering legal questions. A word of thanks goes to Doctor W. C. Woodward of the A.M.A. Medico-Legal Bureau for his help in several cases. And to William J. Burns, the Executive Secretary, our thanks for much coöperation.

The Committee has developed into a sort of in-

formation bureau for other things that are not just medico-legal. We do our best to answer all questions. Of course, most of the work is in answering inquiries and in consultation with doctors who have problems along medico-legal lines. Sometimes it is just a question to be answered over the telephone. Other cases require consultation with the doctor. Here is where Doctor McLean so often comes into the picture. The three of us get together and discuss the matter. Many letters are answered from out of town doctors who write in. It has never been thought necessary to keep an exact record of these cases unless it is unique.

The Committee is pleased to have received during the year several letters of appreciation for the work of our attorneys and the Committee. As much of the matter discussed is confidential in character, our report does not give complete details.

Respectfully submitted,

ANGUS McLEAN, M.D.,

*Chairman*,

I. W. GREENE, M.D.

D. W. HART, M.D.

WM. R. TORGERSON, M.D.

WM. J. STAPLETON, JR., M.D.

\* \* \*

The report was referred to the County Societies Committee.

8. *Report of Councilors.*—Dr. Greene as Chairman of the County Societies Committee presented the tabulated reports of Councilors on the condition of the profession in their districts. This was augmented by verbal reports of the individual councilors. Dr. Greene's summation was (a) Where a county society has a general fund or treasury surplus, there seems to be greater enthusiasm, larger membership and better attendance; (b) social activities, such as dinner meetings and at least one annual party, seem to help esprit de corps.

\* \* \*

Reports referred to the County Societies Committee.

The First Session recessed at 12:30 P. M.

#### Second Session of the Council

The Second Session convened at 1:30 P. M.

9. *Committee on Scientific Work.*—Report was given by Secretary Foster on plans for the 1938 Annual Meeting. To conserve time at the first session of the House of Delegates, the matter of placing the A.M.A. Delegates' report in the Handbook for M.S.M.S. Delegates was discussed. Motion of Dr. Riley seconded by several that the A.M.A. Delegates be requested to prepare their report for publishing in the Handbook. Carried unanimously.

The Secretary reported that the technical exhibit of seventy-six spaces was practically sold out.

10. *Reports of other Committees.*—Drs. L. W. Shaffer, R. H. Pino, P. A. Klebba, O. A. Brines, B. R. Corbus, and M. H. Hoffmann entered the meeting.

The various committee chairmen reported for their committees, as follows:

(a) Dr. Luce for Mental Hygiene Committee. Referred to County Societies Committee.

(b) Dr. Foster for Public Relations Committee. Referred to County Societies Committee.

(c) Dr. Riley for Advisory Committee to Parole Commission. Referred to County Societies Committee.

(d) Dr. Cook for Nurses Training School Committee. (No action taken.)



(e) Dr. Miner for Iodized Salt Committee. Referred to Finance Committee.

(f) Dr. Porter for Ethics Committee. Referred to County Societies Committee.

(g) Dr. Tuck for Michigan Health League. Referred to County Societies Committee.

(h) Dr. Cole for Radio Committee. Referred to County Societies Committee.

(i) Dr. Corbus for Joint Committee on Health Education. Referred to County Societies and Finance.

(j) Dr. Campbell for Maternal Health Committee. Referred to County Societies and Finance.

(k) Dr. Brines for Cancer Committee. Referred to Finance Committee.

(l) Dr. Collisi for Advisory Committee to Woman's Auxiliary. Referred to Finance and County Societies.

(m) Dr. Gruber for Liaison with Hospitals. Referred to County Societies Committee.

(n) Dr. Denham for Liaison with State Bar. Referred to County Societies Committee.

(o) Dr. Klebba for Advisory Committee on Occupational Diseases. Referred to County Societies Committee.

Motion of Dr. Holmes-Greene that portions of the Krogstad Conference on Occupational Diseases be published in the M.S.M.S. JOURNAL. Carried unanimously.

(p) Dr. Pino for the Committee on Distribution of Medical Care. Referred to County Societies Committee and Finance Committee.

11. *Bills Payable*.—Bills payable for the month were presented, studied, and on motion of Drs. Carstens-McIntyre ordered paid.

12. *Basic Science Board*.—The Executive Secretary reported on the status of these appointments.

13. *Physician at Football Games*.—The correspondence urging the necessity of a doctor of medicine at all football games was read and discussed. Motion of Drs. Cummings-Andrews that the matter be referred to the Michigan School Health Association. Carried unanimously.

14. *Uniform Narcotic Drug Act*.—A letter from Dr. Wm. M. Donald suggesting that the act be tested for its constitutionality was read and discussed. Motion of Drs. Cummings-McIntyre that the matter be referred to the M.S.M.S. Legislative Committee for further study, and report to the Executive Committee at a later date. Carried unanimously.

The Second Session was recessed at 5:20 P. M.

### Third Session of the Council

The Third Session was convened at 7:30 P. M.

15. *Proposed Change in Constitution*.—The suggestion that a recommendation be made to the House of Delegates to change Article Three, Section One, so that active membership in a county medical society shall include active membership in the State Society, was discussed. Motion of Drs. Haughey-Brunk that the matter be studied by a committee to be appointed by the Chair. Carried unanimously.

16. *Additional Committee Reports*.—(a) Dr. Hoffmann reported for the Membership Committee. Referred to the County Societies Committee.

(b) Dr. J. D. Bruce presented the report of the Committee on Postgraduate Medical Education, which was referred to the County Societies Committee and the Finance Committee.

### REPORT OF COMMITTEE ON POST-GRADUATE MEDICAL EDUCATION

The Council has received the report on post-graduate activities for the year 1936-1937.

The total attendance of physicians on all courses for that period was 1,589, divided as follows:

Intensive Intramural Courses (Ann Arbor and Detroit) .....	354
Extramural Courses .....	1,107
Courses in the Upper Peninsula and in the upper part of the Lower Peninsula in Maternal and Child Welfare under Federal Aid through the State Department of Health.....	128
Total .....	1,589

In the extramural courses, 592 physicians attended from 50 to 100 per cent of the eight presentations.

The attendance from outside of the State has increased over previous years. Of the 354 physicians coming to Ann Arbor and Detroit, ninety-two, or 25 per cent, were from outside the State. Fourteen states and two Canadian provinces were represented. Ohio headed the list. Indiana, Ontario and New York were next, with smaller numbers from Wisconsin, Texas, Pennsylvania, Oklahoma, New Jersey, Massachusetts, Kentucky, Iowa, Illinois, California and Alabama.

On December 16, 1937, the Advisory Committee on Postgraduate Education met at the Wayne County Medical Building, Detroit. Besides the chairman, Dr. James D. Bruce, those present included Drs. A. P. Biddle, B. R. Corbus, H. H. Cummings, W. B. Fillinger, G. C. Penberthy, R. R. Smith, D. T. Sugar and C. C. Slemmons; also Dr. P. R. Urmston, chairman of the Council; Dr. L. F. Foster, secretary; Wm. J. Burns, executive secretary; Dr. M. R. Kinde, of the W. K. Kellogg Foundation, and Dr. Hamilton H. Anderson, who was making a survey of postgraduate education for the American Medical Association.

A report of attendance on the autumn extramural course for 1937 was made. This showed a decrease of approximately 13 per cent, as against an increase of 15 to 20 per cent each year over the past three years. Comparing the attendance records, it will be seen that the northern center of Traverse City-Cadillac-Manistee-Petoskey slightly exceeded the 1936 attendance. Battle Creek-Kalamazoo also showed some increase. The Bay City attendance was approximately the same, while Flint, Grand Rapids and Lansing-Jackson showed a decrease of, approximately, 20 per cent.

Dr. R. R. Smith reported that Councilor V. M. Moore, of Grand Rapids, feels that the physicians in his district would attend in larger numbers if the time of the meetings were changed to late afternoon and early evening, with a dinner between the two sessions.

The Committee felt that the hours for the meetings should be arranged between the different centers and the Postgraduate Committee.

Dr. W. R. Fillinger stated that the acoustics in one of the Grand Rapids hospitals were very poor. Dr. Smith volunteered to investigate this matter and report to the chairman.

The chairman raised the question of decreasing the number of teaching days from eight to seven or, possibly, six, and the establishment of a new center to serve particularly the countries of Lenawee, Monroe, Livingston, Jackson and Washtenaw. The latter might be done through a re-arrangement of the Jackson-Lansing center, making Lansing a single center and establishing a joint center between Jackson and Adrian; or, by continuing the Jackson-Lansing center, and establishing a new center at Ann Arbor, which would serve these counties equal-



ly well. This would have the added advantage of greater hospital, laboratory and clinical facilities. The Committee favored a re-arrangement but did not make a specific recommendation.

Various methods were suggested to assist the local councilors in the maintenance of interest in these courses and to help in making suitable local arrangements. It was thought that the appointment of two men might be helpful—the first, an older man, well established in the community; and the other, a younger man to whom many of the details might be assigned.

It was further suggested that, in addition to the notifications sent out well in advance of the course by the chairman of the Committee, each county secretary should send out notices to the membership in his district, these notices to be sent about a week before the beginning of the course and the expense of printing and mailing borne by the county societies. While these suggestions were endorsed by the Committee, later in the discussion both Dr. Foster and Mr. Burns thought better results might be had by having these notices sent out from the central office at Lansing, under the conditions outlined for the county societies.

It was felt by the Committee that, in addition to the work of the Councilor and such aides as should be given him, each county society should assume a considerable measure of responsibility in furthering the postgraduate program of the Society.

The matter of certification for those physicians who have met the requirements of the extramural four-year period, or who have done comparable work, was discussed. The Committee approved the plan of presenting the certificates at an evening session during the annual meeting of the State Medical Society. This is in accord with former recommendations and approval of the House of Delegates in the 1937 session. It was agreed that a blank be given at the State meeting—the usual custom in larger groups—and that the certificates be sent to each county society for presentation at a regular meeting of the society.

It was also suggested that the Biddle lecture be given the same evening that the certificates are presented.

The chairman drew attention to the recommendation of the Council that the syllabus of lectures be given only to those who had attended 50 per cent or more of the four-year autumn course, or the Practitioner's Course given each year in Detroit over a like period.

Inasmuch as a number of men had attended the requisite number of lectures in former years, and this year's failure might have been unavoidable, the Committee decided to send the volume to some 450 physicians who had less than the requisite attendance record, with a statement for one dollar, requesting that the volume be returned if they did not wish to keep it. Approximately two hundred physicians sent checks or currency and about twenty volumes were returned, leaving about two hundred and thirty volumes that have not been returned or paid for. Mr. Burns volunteered to send an additional notice to those who have not yet responded. As there are many requests from those who have not had an opportunity to purchase these volumes, their return by those not interested in retaining them would be greatly appreciated.

Since the publication of the volume is an item of considerable expense, costing, including postage, about \$1,000, the Committee advised that subscriptions at the cost price of the volume be taken at the autumn lectures, to be paid for upon delivery. This recommendation is to be subject to Council action.

A list of subjects for the course in 1938 was presented to the Committee, and was approved; also, the suggestion of the chairman of sending a quite complete preview of the presentations to the profession prior to the beginning of the course.

During the dinner hour there was a discussion of postgraduate education, with general agreement that it was one of the most important activities of the Society.

Dr. Foster and Mr. Burns volunteered to handle all news releases pertaining to our educational programs through the executive offices in Lansing.—(Report of Committee from notes taken by Dr. H. H. Cummings at the meeting on December 16, 1937.)

According to the custom in previous years, the Committee sent out a questionnaire to all registrants. The form has varied from year to year, but has always included a request for suggestions, criticisms, comments, and sometimes for specific information. This year's questionnaire was sent in the form of a return postal card, as follows:

December 28, 1937

Dear Doctor:

Every year we have received many comments and suggestions from the registrants of the postgraduate course, which have been very helpful in formulating new programs. We are trying constantly to make these programs as helpful as possible to our members. Would you be kind enough, on the return postal card, to give us what assistance you can in formulating the 1938 program?

With every good wish for a happy and successful New Year, we are,

Cordially yours,

Advisory Committee on Postgraduate Education

The return card, with questionnaire, was as follows:

#### ADVISORY COMMITTEE ON POSTGRADUATE EDUCATION

Ann Arbor, Michigan

1. Subjects suggested for 1938.
2. I favor the hours:
  - (a) 9 a. m. to 1 p. m. \_\_\_\_\_
  - (b) 1 p. m. to 5 p. m. \_\_\_\_\_
  - (c) 4 p. m. to 8 or 9 p. m., including dinner at or near place of meeting. \_\_\_\_\_
  - (d) The present hours of 10:30 a. m. to 2:30 p. m. \_\_\_\_\_
3. I favor a reduction from the present 8-day schedule to (a) 7 or (b) 6 days. (Underline one.)
4. Further comments.

(Signed) \_\_\_\_\_

The card was sent to 904 of those in attendance on last autumn's course. Sixteen names appeared on the registration list for which addresses could not be found. About 400 replies have been received. Of these, approximately 350 have been tabulated, with the following results:

*Question 1. Subjects suggested for 1938.* One hundred and twenty-three physicians suggested subject matter for the 1938 autumn course. There were many helpful suggestions in this list which will be considered by the Committee before the program is finally decided upon.

*Question 2 related to choice of hours for the presentations.*

- (a) 9 a.m. to 1 p.m. ....87
- (b) 1 p.m. to 5 p.m. ....56—17=39
- (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting.... 51
- (d) The present hours of 10:30 a.m. to 2:30 p.m. ....138

It will be noted in this connection that the 1:00-5:00 hours had already been chosen by the Traverse City-Cadillac-Manistee-Petoskey group, and their meetings held last year within those hours. The number replying from this area has been subtracted from the total of votes for the 1:00 to 5:00 p.m. hours, so not to prejudice the vote for this period.

The vote according to centers is as follows:



## MID-WINTER MEETING OF THE COUNCIL

### *Traverse City-Cadillac-Manistee-Petoskey*

- (a) 9 a.m. to 1 p.m. 4  
 (b) 1 p.m. to 5 p.m. (present hours) 17  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 5  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 3  
 94 cards sent to Traverse City-Cadillac-Manistee-Petoskey center. 30 replies, or 30 per cent.

### *Grand Rapids*

- (a) 9 a.m. to 1 p.m. 14  
 (b) 1 p.m. to 5 p.m. 5  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 16  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 34  
 172 cards sent to Grand Rapids center. 73 replies, or approximately 40 per cent.

### *Lansing-Jackson*

- (a) 9 a.m. to 1 p.m. 17  
 (b) 1 p.m. to 5 p.m. 21  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 4  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 26  
 169 cards sent to Lansing-Jackson. 69 replies, or approximately 40 per cent.

### *Flint*

- (a) 9 a.m. to 1 p.m. 8  
 (b) 1 p.m. to 5 p.m. 5  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 4  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 13  
 132 cards sent to Flint. 32 replies, or approximately 25 per cent.

### *Battle Creek-Kalamazoo*

- (a) 9 a.m. to 1 p.m. 28  
 (b) 1 p.m. to 5 p.m. 1  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 10  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 32  
 179 cards sent to Battle Creek-Kalamazoo. 71 replies, or approximately 40 per cent.

### *Bay City*

- (a) 9 a.m. to 1 p.m. 21  
 (b) 1 p.m. to 5 p.m. 2  
 (c) 4 p.m. to 8 or 9 p.m., including dinner at or near the place of meeting 5  
 (d) The present hours of 10:30 a.m. to 2:30 p.m. 33  
 153 cards sent to Bay City. 61 replies, or approximately 40 per cent.

**Question 3.** Choice of present 8-day schedule, or a reduction to (a) 7, or (b) 6 days.

The replies to this question were as follows: Practically all were in favor of the eight-day schedule. Eleven favored a reduction to seven or six days, while several asked that the number of days be increased.

**Question 4. Further comments.** There were a few criticisms of the manner of presentations. Still more urged that the meetings begin promptly on time. Approximately 70 per cent had nothing but praise for the work, and all urged its continuance. It is interesting and extremely gratifying to receive 136 excellent suggestions. Of the criticisms, all were constructive, and approval of the general plan of the extramural program was unanimous.

Mr. Burns has asked that request for funds be made to support the postgraduate program. If a seventh center is established, there will be an added expense of, approximately, \$400, and if the needs of the Upper Peninsula and the northeastern section of the State are to be met with reasonable adequacy, there will be an estimated increase of, at least, another \$400. On the basis of last year's contribution, this would mean setting aside \$2,300. This is based on the assumption that the autumn course and the practitioners' course of one week in May, in Detroit, will not be subject to a fee, and that the published résumé of presentations will be supplied at cost to those desiring to keep the proceedings up to date. It is suggested that this amount be considered.

It is now twelve years this month since the Council invited the faculties of our two medical schools to meet with it for a discussion of ways and means

to provide for the postgraduate needs of the Michigan profession. The progress of this movement during the intervening years has been so significant as to mark the year 1926 as a milestone in the medical history of Michigan. Increasing interest is shown all over the country, as evidenced by the meeting during the 1937 session of the American Medical Association of accredited representatives from over half of the state medical societies, and their determination to go forward in a united effort to ascertain how increasing postgraduate needs might best be met. This action was coincident with the appointment by the Council on Medical Education of the American Medical Association of a commission which proposes a three-year study of all post-collegiate medical educational activities and needs. The early recognition by the Council of the Michigan State Medical Society of the obligation to provide for the continuing education of our profession may be viewed with justifiable pride.

The interest shown by many groups of our citizens and by government itself in medical care and the alleged disastrous results of governmentally controlled medical services in many foreign countries place a great responsibility upon the American profession. As doctors are individualists to a notable degree, undoubtedly opinions will differ widely as to the importance of these problems and how they best be met. While the questions of distribution of service and payment therefor are important issues that must be met, the outstanding problems undoubtedly concern the quality of medical service.

Adequate professional preparedness through continuing education and information to the public as to what constitutes good medical service, as well as how the health needs of the people had best be met, are the present objectives of the program in Postgraduate Medicine and that of the Joint Committee on Health Education. These interests and objectives, serving importantly in protecting the public and in perpetuating medical ideals, should be accorded continuous support.

\* \* \*

General discussion of Michigan's postgraduate medical education ensued, with each Councilor presenting his suggestions and criticisms as gleaned from physicians in his district. Dr. Bruce felt that the future of medicine depends upon the quality of medical service given by the average practitioner of medicine; that postgraduate medical education is raising the quality of practice, and that the public is being educated in medical matters to an amazing degree.

The Third Session was recessed at 9:50 P. M.

## Fourth Session of the Council

The Fourth Session convened at 9:15 A. M.

17. *Reference Report of Committee on County Societies.*—Dr. Greene presented the report of his committee, covering seventeen points which were discussed individually and approved item by item.

## REFERENCE REPORT OF COMMITTEE ON COUNTY SOCIETIES

1. *Secretary's Report.*—The general report was approved and all recommendations are concurred in except No. 1, which we would advise should read, "A concerted membership drive be instituted during the months of February, March and April, 1938, and during the same period during subsequent years as far as it is in accord with the recommendations of the Membership Committee of the State Society; and it is further suggested that the recom-



mendations of the Public Relations Committee be captioned separately in the Secretary's Letter so that it will be understood that this committee is functioning.

2. *Membership Committee.*—We approve of Dr. Hoffmann's report and recommend that the ideas brought forth in his report be presented to the Secretaries at the Annual Conference on January 23, 1938.

3. *Medico-Legal Committee.*—We fully endorse and approve the report of the Medico-Legal Committee.

4. *Advisory Committee on Syphilis Control.*—Committee report approved as far as submitted.

5. *Radio Committee.*—We approve of the report and wish to thank the committee for its work and suggest that the coöperating radio stations be given a letter of thanks by the State Society.

6. *Maternal Health Committee.*—We recommend the report be approved but suggest that efforts along the line of lay education be carefully studied and that the major emphasis be put upon the education of the physician.

7. *Mental Hygiene Committee.*—We approve the report and further recommend that talks given along the line of mental hygiene and allied subjects, be not too technical in their language and so presented as to be of aid to the general practitioner in coping with these problems.

8. *Advisory Committee to Parole Commission.*—Approve and recommend that the contact be continued.

9. *Ethics Committee.*—We approve the report.

10. *Advisory Committee to the Woman's Auxiliary.*—We approve the report.

11. *Liaison Committee with State Bar of Michigan.*—We approve and recommend that the Executive Committee formulate such policies as are necessary in guiding this committee.

12. *Liaison Committee with State Hospital Association.*—We approve the report.

13. *Committee on Health League.*—We approve the report.

14. *Advisory Committee on Occupational Diseases.*—We approve action up to date and recommend further study.

15. *Joint Committee on Health Education.*—We approve the report.

16. *Committee on Distribution of Medical Care.*—We accept the report and approve the questionnaire, but advise the questionnaire be abbreviated, edited, and distributed to the Secretaries on the occasion of their annual conference in Lansing, January 23.

17. *Reports of Councilors.*—We believe that the various councilors have covered their districts very well and that they have been in good contact with their county societies and we approve their activities and advise semi-annual reports be made in future, with questionnaires being mailed out well in advance of general council meetings.

Motion of Dr. Greene, seconded by several, that the report as a whole be adopted. Carried unanimously.

18. *Reference Report of Publications Committee.*—Dr. Brunk presented the report of his committee, covering nine points which were discussed individually and approved item by item.

## REFERENCE REPORT OF PUBLICATIONS COMMITTEE

1. Your Publications Committee met on January 12 and discussed the following matters, some of which were referred to it by The Council:

(a) *Size of Journal.* Motion of Drs. Holmes-McIntyre that the Publications Committee respectfully recommend to The Council that THE JOURNAL be limited to approximately 100 pages per issue, in the interests of economy. Carried.

(b) *County Society News.* Motion of Drs. Andrews-Heavenrich that the Editor be instructed to limit the county society news reports to a maximum of ten lines each month, per society, except under extraordinary circumstances, and that the Secretary be instructed to present this matter at the County Secretaries' Conference on January 23.

Also that the Woman's Auxiliary and the State Board of Health News each be submitted to the Editor each month and be allotted not more than 1½ pages per month. Carried.

(c) *Distillery Advertising.* Motion of Drs. McIntyre-Heavenrich that the Publications Committee respectfully recommend to The Council that THE JOURNAL may list high-grade distillery and brewery advertising in its pages. Carried unanimously.

(d) *Editor's Report.* Motion of Drs. Holmes-McIntyre that the report of the Editor, as submitted to The Council, be accepted. Carried unanimously.

(e) *Mattson Pension.* Motion of Drs. Heavenrich-McIntyre that this Committee report to The Council this problem, for an opinion, with the suggestion that the Secretaries secure an opinion at the A.M.A. in Chicago as to the status of the case and what other state medical societies are doing, and thereafter report to the Executive Committee. Carried.

(f) *Professional Cards.* Motion of Drs. Andrews-McIntyre that this Committee recommend to The Council that no action be taken. Carried unanimously.

(g) *Journal Budget.* The budget was studied and referred to the Budget Committee, with the recommendation that it take into consideration that there will be less advertising revenue and increased cost for printing, ink and paper during 1938.

(h) *Advertising Solicitor.* Motion of Drs. McIntyre-Heavenrich that the securing of additional advertising solicitors be recommended to The Council for approval. Carried unanimously.

(i) *Report of Chairman of Publications Committee.* This was read and approved, with the recommendation that it be presented to The Council with the above matters.

Motion of Drs. Andrews-McIntyre that the report as a whole be adopted. Carried unanimously.

19. *Additional Committee Reports.*—State Health Commissioner Don W. Gudakunst, and Drs. L. O. Geib, B. H. Douglas and L. W. Shaffer entered the meeting. Dr. Geib presented the report of the Preventive Medicine Committee; Dr. Douglas presented the report of the Advisory Committee on Tuberculosis Control; Dr. Shaffer presented the report of the Advisory Committee on Syphilis Control.

Commissioner Gudakunst was welcomed by The Council, and discussed the type of health service in this state together with needs for the future, including a medical coördinator of preventive medicine procedures.

Motion of Drs. Greene-Sherman that the report of the Advisory Committee on Tuberculosis Control be adopted, that the Public Relations Committee of the M.S.M.S. integrate the work of the Committee to the M.S.M.S. membership, and that the coöperation of the Governor's Coördinating



Committee be sought in this activity. Carried unanimously.

Motion of Drs. Greene-Cummings that the report of the Advisory Committee on Syphilis Control be adopted. Carried unanimously.

Motion of Drs. Greene-McIntyre that the report of the Preventive Medicine Committee be adopted. Carried unanimously.

These Committees are to advise Dr. Foster just what projects they wish the Public Relations Committee to integrate. Motion of Drs. Cummings-McIntyre that the Preventive Medicine Committee prepare statements and statistics which may be presented to supervisors in the various counties to prove that preventive procedures, by the early treatment of syphilis, tuberculosis, etc., will save money in the long run by cutting down long-time institutional care. Carried unanimously.

20. *Violations*.—Dr. McIntyre, Secretary of the State Board of Registration in Medicine, presented a coöperative arrangement with the State Department of Health to curb violations of the Medical Practice Act.

21. *Fees for Insurance Information*.—Dr. C. E. Umphrey, President of the Wayne County Medical Society, and Mr. James A. Bechtel, its Executive Secretary, entered the meeting to discuss the M.S. House of Delegates' resolutions of 1929 and 1937 re fees for insurance information. The matter was thoroughly discussed to the satisfaction of President Umphrey. Any problems may be clarified at the 1938 meeting of the M.S.M.S. House of Delegates.

22. *Medico-Legal Committee*.—The activity of the Medico-Legal Committee was thoroughly discussed, together with a study of the By-Laws governing this work. Motion of Drs. Andrews-McIntyre that all members of the present committee, except Dr. Hart, be reappointed, and that Dr. S. W. Donaldson be named to the vacancy. Carried unanimously. (Secretary Foster explained that Dr. Hart had another committee appointment which would keep him very busy.)

Motion of Drs. McIntyre-Moore that Dr. Angus McLean be elected as Chairman of the Medico-Legal Committee. Carried unanimously.

Motion of Drs. Carstens-Cummings that The Council vote no salary for the Chairman, but \$1,000 for 1938 for the Secretary of the Medico-Legal Committee. Carried unanimously.

The Fourth Session was recessed at 12:30 P. M.

## Fifth Session of the Council

The Fifth Session convened at 1:30 P. M.

23. *Afflicted-Crippled Child Laws*.—Dr. H. B. Fenech of the Crippled Children Commission, and Dr. E. R. Witwer of the Michigan Association of Roentgenologists, were present to discuss recent developments in connection with the afflicted-crippled child laws. The Council decided that representatives of the M.S.M.S. should be present at all meetings of the C.C.C. and of the Auditor General at which revision of the fee schedules, to be republished as of March 1, 1938, will be discussed. The matter will be studied by the x-ray group in February. Dr. Witwer stated that his group would undoubtedly request a revision of the original x-ray fee schedule, and also for a clearer understanding of arrangements re x-ray work. Commissioner Fenech stated that the Attorney General had ruled that the flat rate for hospitals is illegal.

24. *Newspaper Headlines*.—Dr. L. J. Hirschman was present and invited the attention of The Coun-

cil to unfortunate newspaper headlines such as "Under the Knife." He recommended that the newspapers be requested to eliminate terrifying headlines, and to keep out of stories the names of hospitals wherein deaths from ordinary causes resulted.

President Cook will appoint a committee to contact the newspapers.

## REFERENCE REPORT OF FINANCE COMMITTEE

25. *Reference Report of Finance Committee*.—Presented by Dr. H. R. Carstens. Dr. Carstens gave a résumé on the financial condition of the Society for 1937, based on the Auditor's report. He predicted a loss in JOURNAL advertising for 1938. Motion of Drs. Andrews-Holmes that the inventory item covering the "Medical History of Michigan" be stricken off the M.S.M.S. books as an asset. Carried unanimously. Motion of Dr. Holmes, seconded by several, that at the Secretaries' Conference of January 23, the Medical History of Michigan be distributed to the county society secretaries for libraries (local, public, medical, and hospital libraries). Carried unanimously.

Dr. Carstens presented the proposed budget for 1938, which was discussed item by item. Motion of Drs. Greene-Holmes that the Medico-Legal Fund be allotted \$3,500 for 1938 expenses. Carried unanimously.

Motion of Drs. Holmes-Cummings that the amount for "Delegates to A.M.A." be set at \$1,200, and that the Executive Committee decide, with what money is left from the delegates' expenses, what officers of the M.S.M.S. can be sent to the A.M.A. meeting. Carried unanimously.

Motion of Drs. Brunk-Haughey that the budget as presented by the Finance Committee Chairman be adopted. Carried unanimously. THE JOURNAL budget, as presented, was approved on motion of Drs. Carstens-Cummings. Carried unanimously.

### SOCIETY BUDGET FOR 1938

#### INCOME

4,100 members at \$12	
(less ½ and ¼ dues of any new members)...	\$ 48,200.00
Interest .....	900.00
Total income .....	\$ 49,100.00
Less allotment to Medico-Legal Fund....	3,500.00
Less allotment to THE JOURNAL .....	6,000.00
Total Net Income .....	\$ 39,600.00

#### APPROPRIATIONS:

<i>Administrative and General:</i>	
Medical Secretary Salary .....	2,400.00
Executive Office Salaries .....	9,960.00
Extra Office Help .....	100.00
Office Rent and Light .....	735.00
Printing, Stationery, Supplies .....	900.00
Postage .....	750.00
Insurance and Fidelity Bonds .....	185.00
Auditing .....	175.00
New Equipment .....	400.00
Telephone and Telegraph .....	400.00
Miscellaneous .....	150.00

Total Administrative and General.....\$ 16,155.00

<i>Society Expenses:</i>	
Council Expense .....	2,750.00
Delegates to A.M.A. ....	1,200.00
Secretaries Conferences .....	850.00
General Society Travel Expense .....	1,600.00
Secretary's Letters .....	350.00
Publications Expense .....	500.00
Reporting Annual Meeting .....	125.00
Education Expenses .....	500.00
Legal Expense .....	250.00
Sundry Society Expenses .....	550.00
Organizational Expense .....	3,500.00
Contingent Fund .....	4,370.00

Total Society Expense .....

Less gain from Annual Meeting..... 750.00

Net Society Expense .....

JOUR. M.S.M.S.



## MID-WINTER MEETING OF THE COUNCIL

### Committee Expenses.

Legislative Committee .....	1,000.00
Committee on Distribution of Medical Care..	200.00
Cancer Committee .....	650.00
Preventive Medicine Committee:	
(Including Adv. on Syphilis and Adv. on Tuberculosis Control.) .....	500.00
Radio Committee .....	25.00
Postgraduate Medical Education .....	2,000.00
Maternal Health Committee .....	250.00
Goitre (Iodized Salt Committee) .....	250.00
Public Relations Committee .....	700.00
Ethics Committee .....	100.00
Membership Committee .....	50.00
Repre. to Joint Com. on H. E. ....	1,000.00
Adv. to Woman's Auxiliary .....	50.00
Committee on Health League .....	150.00
Sundry Other Committees .....	325.00
Committee Reserve .....	400.00

Total Committee Expenses.....\$ 7,650.00

Grand Total .....\$ 39,600.00

### BUDGET FOR "THE JOURNAL"—1938

#### INCOME:

Subscriptions .....	\$6,000.00
Advertising .....	8,550.00
Reprint sales .....	300.00

Total Journal Income ..... \$14,850.00

#### EXPENSES:

Editor's Salary .....	\$3,000.00
Editor's Expense .....	600.00
Printing and Mailing .....	9,550.00
Discounts & Commissions .....	1,250.00
Postage .....	300.00
Reserve .....	150.00

Total Journal Expenses ..... \$14,850.00

26. *1939 Annual Meeting.*—Council Moore presented the invitation of the Kent County Medical Society requesting that the 1939 Annual Meeting of the M.S.M.S. be held in Grand Rapids. Dr. Moore was thanked and the invitation was referred to the House of Delegates.

27. *Permanent Delegates to A.M.A.*—The suggestion that the Secretary and President-Elect of the M.S.M.S. be made permanent delegates to the A.M.A. was referred to the House of Delegates.

28. *Councilors' Expenses.*—Motion of Drs. Holmes-Barstow that the M.S.M.S. pay all expenses of the councilors incurred in the course of their duties within their own districts and at all regular meetings of The Council and of the Executive Committee. No other expenses shall be paid unless previously authorized by the Chairman of The Council. Carried unanimously.

29. *Michigan Health League.*—Dr. Greene reported on the proposed Constitution and By-Laws of the Michigan Health League, and moved that The Council approve of the principles of the Michigan Health League as proposed in the draft of its Constitution and By-Laws. Seconded by Dr. Cummings and carried unanimously.

30. *Filter System.*—Councilor Cummings reported on the filter system in Washtenaw County. The Council felt that the Washtenaw County Medical Society and all other societies should be urged to continue their filter committee and work in connection with the Afflicted Child Law.

31. *Wisconsin's Study of Distribution of Sick-ness Care.*—A report on this activity was presented by Secretary Foster, who felt that a similar program might be attempted in Michigan in connection with the holding of "State Society Nights" in various parts of the state, at little additional expense. Motion of Drs. Barstow-Heavenrich that The Council approve this plan. Carried unanimously.

32. *Survey of Medical Relief Cases.*—The survey of 1937 medical relief, proposed by Dr. R. G. Tuck and recommended by Dr. R. H. Pino, was

approved; motion of Drs. Haughey-Carstens that the M.S.M.S. request this information from the Michigan E.R.A. Carried unanimously.

33. *Use of Title "Dr."*—Secretary Foster reported on the request of a Grand Rapids citizen and a Lansing attorney that action be taken to limit the use of the title "Doctor" to those entitled to same. This matter was referred to the Legislative Committee, to the State Board of Registration in Medicine, and to such others as are interested in the problem.

34. *Placement Service.*—The Executive Secretary reported on activities to date. Several opportunities for a young physician were mentioned.

Dr. Manthei's report on the problem at Amasa was presented and ordered placed on file.

\* \* \*

## ELECTIONS

35. *Election of Secretary.*—Motion of Drs. Greene-Holmes that Dr. L. Fernald Foster be nominated to succeed himself as Secretary. Carried. Motion of Drs. Cummings-Heavenrich that the Secretary of this meeting be instructed to cast a ballot for Dr. Foster as M.S.M.S. Secretary. Carried unanimously. The Secretary did so cast, and Dr. Foster was announced by the Chair as Secretary of the M.S.M.S.

36. *Election of Treasurer.*—Motion of Drs. Moore-Brunk that Dr. Wm. A. Hyland be nominated to succeed himself as Treasurer. Carried. Motion of Dr. Moore, seconded by several, that the secretary of this meeting be instructed to cast the ballot for Dr. Hyland as M.S.M.S. Treasurer. Carried unanimously. The secretary did so cast, and Dr. Hyland was announced by the Chair as Treasurer of the M.S.M.S.

37. *Election of Editor.*—Motion of Dr. Holmes, seconded by several, that Dr. James H. Dempster be nominated to succeed himself as Editor. Carried. Motion of Dr. Cummings, seconded by several, that the secretary of this meeting be instructed to cast a ballot for Dr. Dempster as M.S.M.S. Editor. Carried unanimously. The secretary did so cast, and Dr. Dempster was announced by the Chair as Editor of the M.S.M.S. JOURNAL.

38. *Appointment of Executive Secretary.*—Motion of Drs. Carstens-Cummings that Wm. J. Burns be re-appointed as Executive Secretary. Carried unanimously.

Motion of Drs. Barstow-Sladek that Mr. Burns be given a vote of commendation and appreciation for his work in behalf of the M.S.M.S. Carried unanimously.

39. *Adjournment.*—The Mid-winter Meeting of The Council was adjourned at 4:00 p.m. The Chair thanked all for their attendance, patience, and good service.

The Councilors in turn expressed appreciation to Chairman Urmston for his hospitality and his efficiency in conducting this meeting.

## Business Side of Medicine

(Continued from page 259)

March to June, went up in July and August, and tapered off again somewhere during the months of September, October or November.

(4) Both Business and Cash figures in 1937 were slightly more than 15 per cent higher than in 1936.



## COUNTY SOCIETIES

### ALPENA-ALCONA-PRESQUE ISLE COUNTIES

HAROLD KESSLER, M.D.  
*Secretary*

The January meeting of the Alpena County Medical Society was held on January 28, 1938, at the Owl Cafe, Alpena. President W. E. Nesbitt of Alpena called the meeting to order.

The question of erection of a new hospital was discussed and the Secretary instructed to obtain as much information as possible relative to financing such a project and report to the Society next month.

The speaker of the evening, Dr. W. E. Nesbitt, spoke on "Pneumothorax." The talk was illustrated with the demonstration of the machine used in treatment, with numerous x-ray films showing the results obtained.

### BAY-ARENAC-GLADWIN IOSCO COUNTIES

A. L. ZILIAK, M.D.  
*Secretary*

The Bay County Medical Society held a regular dinner meeting Wednesday, January 12, 1938. Dr. Gordon Myers, Professor of Medicine at Wayne University, gave an interesting talk on "Pneumonia."

On January 26, the members heard Dr. John Barnwell of the University of Michigan give an illustrated talk on "Bronchitis and Bronchial Obstruction in the Tuberculous."

The Society decided to devote one meeting each month to a scientific paper and one meeting to business and sociability.

Two new members were received into membership: Dr. Harold Henser, Bay City, and Dr. Horace Burton, East Tawas.

### BATTLE CREEK ACADEMY OF MEDICINE

L. R. KEAGLE, M.D.  
*Secretary*

The Battle Creek Academy of Medicine and Dentistry held a dinner meeting on January 25, 1938, at the Kellogg Hotel, Battle Creek. Guests who were present included Mayor R. J. Hamilton, Battle Creek; Judge of Probate Frank Kulp, City Attorney Demond, Albion; Senator D. Hale Brake of Stanton, Victor Blain of ERA, Wm. J. Burns, Executive Secretary of the Michigan State Medical Society; Dr. Hugh Robins, County Health Officer, and William Morgan, Poor Commissioner.

The address of the evening was given by Senator Brake, who discussed fully the welfare legislation passed at the 1937 session of the Michigan Legislature. Senator Brake stated that the controversy over the welfare legislation should not be used as a political football. It should be considered on its merits. It is now a conflict between state and local control. The new bills secure local control more than any other. It is now on referendum and must be voted upon next November. Senator Brake urged the medical profession to support it as a

measure eliminating much of the red tape that has hampered their work so long.

Mr. Burns spoke of the occupational disease law and of the necessity of familiarizing ourselves with the nomenclature of the thirty-one diseases listed therein. It is necessary that the exact terminology be used in reporting cases, else the patient will lose his compensation. Mr. Burns also spoke briefly on the afflicted and crippled children's laws, which require the republishing of the fee schedule every six months. Members of the medical profession were urged to send in suggestions. He suggested that syphilis control programs should be started by each county medical society, which, because of its technical knowledge, must assume medical leadership.

### CALHOUN COUNTY

WILFRID HAUGHEY, M.D.  
*Secretary*

The February meeting of the Calhoun County Medical Society was called to order by President J. E. Rosenfeld at the Post Tavern, Battle Creek, on February 4.

The president announced the appointment of a Cancer Committee. The names of the appointees are: Dr. Fred J. Melges, chairman, Drs. A. A. Humphrey, George W. Slagle, Russell L. Mustard, and Robert H. Fraser.

The secretary read a number of communications from the secretary of the State Medical Society regarding medical aspects of old age pensioners, afflicted children's law and new regulations, et cetera.

Application for membership was presented for Dr. Paul A. L. Black, second reading. By motion of Drs. Cooper and Slagle, he was elected.

First reading applications were presented for Dr. Hugh B. Robbins of Marshall and Dr. James D. Sleight of Battle Creek.

The speaker of the evening, Dr. F. Janney Smith of Henry Ford Hospital, Detroit, was introduced by Dr. Verity. Doctor Smith spoke on "Coronary Artery Disease."

### DICKINSON-IRON COUNTIES

W. H. HURON, M.D.  
*Secretary*

The February meeting of the Dickinson-Iron County Medical Society was held at the Crystal Inn at Crystal Falls, February 9, 1938. Fourteen physicians were present from the two counties.

The committee appointed for drafting a new constitution and by-laws reported the outline which had been sent out by the State Society, and this was accepted with such changes as were necessary for the local society.

Dr. E. M. Libby was elected as delegate to the 1938 meeting of the State Society House of Delegates, and Dr. W. H. Huron was elected as alternate. Dr. J. A. Crowell, of Iron Mountain, who has been practicing medicine in the Upper Peninsula for over fifty years, and who has retained an active membership, was elected a member emeritus. Dr. E. P. Lockart of Norway, who is now past 80 years of age, and who has practiced medicine in this vicinity for well over fifty years, was elected an honorary member of the society.

Dr. B. C. Baron gave a paper on the "Peridural Nerve Block." He reported twenty-nine cases that he had done in conjunction with Dr. Harry Haight of Crystal Falls.

## COUNTY SOCIETIES

### EATON COUNTY

THOMAS WILENSKY, M.D.

*Secretary*

The January meeting of the Eaton County Medical Society was held in Charlotte on January 27, 1938.

Immediately following dinner, President H. A. Moyer introduced the speaker, Dr. J. F. Harrold, urologist, of Lansing, who read a most comprehensive and detailed paper entitled "Sulfanilamide in Urologic Infections." Doctor Harrold was one of the first to use sulfanilamide in urologic infections, and particularly in gonococci infections, and he is most enthusiastic about it, for carefully controlled cases showed decidedly better results than did similar cases treated before sulfanilamide.

The secretary spoke briefly on the discussions which took place at the County Secretaries' Conference held in Lansing on January 23.

The following resolution was presented and adopted unanimously:

"WHEREAS, Dr. J. B. Bradley of Eaton Rapids and Dr. Phil Quick of Olivet having each through personal integrity and constant adherence to Hippocratic concepts of medical practice, erected to themselves towering monuments in the form of fifty years of professional service to their respective communities, therefore,

"BE IT RESOLVED that the Eaton County Medical Society goes on record as urging the House of Delegates of the Michigan State Medical Society to confer upon these two honorable practitioners lifelong and honorary membership in the Michigan State Medical Society."

The Society voted to hold the regular meetings on the third Thursday of the month instead of the last Thursday because of recurring conflicts with various holiday events throughout the year.

The condolences of the Society are sympathetically extended to Dr. Phil Quick, who is confined by illness.

### HILLSDALE COUNTY

E. G. MCGAVRAN, M.D.

*Secretary*

The Hillsdale County Medical Society held two meetings in January, both taking place outside the county.

On January 18, the Hillsdale and Jackson Societies were joint sponsors of a State Officers Meeting, held at the Hayes Hotel, Jackson.

The second meeting of the month was held on January 20 at Sweet's Hotel, Quincy. This was a joint session of the medical societies and veterinarians of Branch and Hillsdale Counties. Dr. B. W. Culver of Coldwater presided. The speaker of the evening, Dr. Paul Brooks, deputy commissioner of health of New York State, was introduced by Dr. R. B. Harkness of Hastings.

Dr. Brooks gave a very interesting address on the subject of "Milk-Borne Outbreaks of Communicable Disease" which was illustrated by a chart of all such outbreaks that have occurred in New York State during the past twenty years. This talk illustrated, forcibly, the need for pasteurization of milk supplies to avoid such outbreaks. Following his address, Dr. Brooks answered a number of questions and particular interest was shown in the new test to determine satisfactory pasteurization of milk on the basis of the presence or absence of a certain enzyme.

### HURON-SANILAC COUNTIES

E. W. BLANCHARD, M.D.

*Secretary*

The annual meeting of the Huron-Sanilac County Medical Society was held at Marlette, January 25,

1938, with thirteen members and two guests present. The following officers were elected:

President—R. R. Gettel, Kinde.

Vice President—R. K. Hart, Croswell.

Secretary-Treasurer—E. W. Blanchard, Deckerville.

Delegate to M.S.M.S.—C. J. Webster, Marlette.

Alternate Delegate—C. W. Oakes, Harbor Beach.

Short talks were given on State Society affairs by Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, and Dr. Paul R. Urms-ton, chairman of The Council, both of Bay City.

Dr. J. O. Lunn addressed the Society on "Iodine in Relation to Thyroid Disease."

### INGHAM COUNTY

R. J. HIMMELBERGER, M.D.

*Secretary*

The annual President's Dinner was held on January 11, 1938, with 178 members and guests present. Dr. Byron Niles acted as toastmaster, and introduced the retiring president, Dr. Milton Shaw, who spoke briefly of the advances made by the Ingham County Medical Society during the past twenty years.

The new president, Dr. Dana M. Snell, was then introduced and he immediately ordered a meeting to be called as a special meeting. Dr. L. C. Towne was recognized by the president and presented a resolution expressing the gratitude and deep appreciation of the Ingham County Medical Society to Dr. Milton Shaw for his long continued self-sacrifice in rendering unselfish service to this community by doing autopsies, and authorizing a committee to be appointed to purchase a suitable token as visible proof of the recognition of this unparalleled service to medicine. The resolution was unanimously adopted and a copy was presented to Doctor Shaw.

### IONIA-MONTCALM COUNTIES

JOHN J. McCANN, M.D.

*Secretary*

The January meeting of the Ionia-Montcalm Medical Society was held on January 11, 1938, at the Reed Inn, Ionia, with Dr. R. R. Whitten, newly elected president, in the chair. Twenty-one members were present. Dr. David B. Davis and Dr. Paul W. Kniskern, both of Grand Rapids, were guests.

Dr. Davis presented a paper entitled "Head Injuries," giving his talk from the viewpoint of the general practitioner. Dr. Kniskern spoke on the practical phases of blood-transfusion.

President Whitten appointed the following committees:

Cancer.—Drs. R. C. Lintner, A. J. Bower, M. A. Hoffs, I. S. Lilly and John R. Hay.

Public Relations.—Dr. C. T. Pankhurst, Chairman.

Constitution and By-Laws.—Drs. P. C. Robertson, W. W. Norris, L. S. Dunkin.

Membership Committee.—Drs. J. A. VanLoo, V. F. Kling, and M. M. Hansen.

### OTTAWA COUNTY

D. C. BLOEMENDAAL, M.D.

*Secretary*

The February meeting of the Ottawa County Medical Society was held Tuesday, February 8, 1938, at the Wm. M. Ferry Hotel, Grand Haven. Twenty members were present. Following a short business session, the meeting was turned over to Dr. Lynn A. Ferguson of Grand Rapids, who spoke on "Rectal Infections." His talk was illustrated with lantern slides.



## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
 Sec. Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
 Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### ITEMS FROM THE STATE SECRETARY

A doctor's wife from an unorganized county writes:

"Because I feel it should be the duty of every doctor's wife to support the Auxiliary at least by membership, I am requesting the necessary blanks."

Perhaps there are other doctors' wives living in unorganized counties who feel the same—remembering, of course, that their husband must be a member of the county medical society for a wife to be eligible. A note to the Treasurer will secure the blanks. When these are filled out and returned with the \$1.00 fee, one becomes an Associate Member of the State and National Auxiliary. While such membership lacks the benefit and pleasure which comes from the contacts within a County Auxiliary, it is a fine way of expressing appreciation of the program and purposes of the organization.

\* \* \*

The prize for promptness (perhaps we really should have one to award) goes to the Monroe County Auxiliary who remitted State and National dues in full on January 16.

\* \* \*

The Mid-Winter Board meeting of the Woman's Auxiliary to the Michigan State Medical Society was held at the Hayes Hotel, Jackson, on December 6, 1937.

The meeting was called to order by the President, Mrs. Hicks. The following members of the Board answered roll call: Officers and Chairmen: Hicks,

Urmston, Page, Wenger, Jeanichen, Ziliak, Pyle, Geib; County Presidents: Howard, Anderson, Vanderzalm, Ludwick, Lang, Snapp, Harvie, Walker.

The minutes of the Pre-Convention and Post-Convention Board meetings were read and approved. The Secretary took the chair while the President presented her report. The Treasurer's report disclosed a balance of \$353.53. Reports from standing committees followed: Advisory Committee, Program, and Public Relations. The Chairman of the Committee on Organization was present, but had no report to make. Both Press Chairman and Legislative Chairman were kept away by illness. A report from the Press Chairman was read by the Secretary. All these reports were approved.

County Presidents from Bay, Calhoun, Eaton, Jackson, Kalamazoo, Kent, Saginaw, and Wayne County Auxiliary reported on the progress of their program. A report from the President of the Monroe County Auxiliary was read by the Secretary.

The Chairman on Revision, Mrs. Geib, reported the printing of 200 copies of the newly adopted Constitution and By-laws and produced them for distribution.

The Treasurer reported that the plan for a card index, as decided upon at the last meeting of the Board, had been dropped, since the experience of the National Auxiliary had led them to conclude that difficulty in getting coöperation made the plan valueless, so they were no longer supplying the cards.

Mrs. Wenger reported that a study of the matter of a state project showed no money available;

## The Forty-ninth Annual Reunion

and

## Detroit Clinics

of the Alumni Association of Wayne University

College of Medicine

will be held at Detroit, June 15 and 16, 1938

she then gave a comprehensive summary of the contents of the National News Letters for 1936-37.

Proceeding to new business, Mrs. Snapp moved and Mrs. Howard seconded her motion that pins should be purchased for the Past Presidents, as well as one to be worn by the acting President. The motion was carried.

Mrs. Wenger moved, seconded by Mrs. Harvie, that the President be sent to the National Convention with expenses paid. The motion was carried.

Mrs. Wenger moved, seconded by Mrs. Geib, that the President-elect be sent to the National meeting with expenses paid. The motion was carried.

Mrs. Wenger moved and Mrs. Ziliak seconded her motion that traveling expenses to the mid-year Board be paid, with an allowance of \$0.06 per mile. The motion carried.

The President declared the meeting adjourned.

(Mrs. J. W.) ETHEL BOYD PAGE, *Secretary*

## COUNTY AUXILIARIES

### Bay County

The Auxiliary met December 15, at the home of Mrs. W. S. Stinson. Thirty-two members were present. After the pot-luck dinner, the business meeting was opened by the president, Mrs. A. L. Ziliak. Mrs. A. D. Allen, *Hygeia* chairman, reported a net profit of thirty-five dollars from a Keno party, given for doctors and their wives, and was instructed to turn this money toward subscriptions for *Hygeia* magazine for the rural schools of our county.

As our membership is becoming too large to be accommodated in private homes, we accepted the offer to hold all future meetings of the year at the Elizabeth Riley Nurses' Home of Mercy Hospital, the dinners to continue to be pot-luck.

On January 12, the Auxiliary met at the Nurses' Home of Mercy Hospital. Thirty-four members were present. Mrs. Ziliak reported that Dr. Brakey of Lansing had been secured to speak here on February 9, his subject to concern the education of the public concerning syphilis. This was counted as our second Public Relation Meeting and was open to the public, free of charge.

Following the business meeting we listened to a very interesting speech by Mrs. Beckwith, supervisor of all work with handicapped children in the public schools of Bay City.

A Benefit Card Party and Tea was held on Valentine's Day at the Nurses' Home.

(Mrs. W. S.) LYNN J. STINSON,  
*Corresponding Secretary*

### Ingham County

On Monday, January 17, the Auxiliary met for an all day sewing meeting at Saint Lawrence Hospital. Mrs. Frank Stiles, chairman of the Welfare Committee, was in charge, and was capably assisted by Mrs. H. A. Wilson, Vice Chairman. Although only a small number attended, the group accomplished a considerable amount of work, making 214 towels, twenty-eight dresser scarfs, forty-nine sheets, and ten pillow cases. Coffee was served at noon by the hospital.

Dr. Clara M. Davis of Chicago, formerly of Lansing, was the guest speaker at the meeting of the auxiliary Monday afternoon, January 24, at the Y.W.C.A. Mrs. G. C. Hicks, state president, and Mrs. J. W. Page, state secretary, both of Jackson, were also guests.

Doctor Davis, a member of the pediatrics staff of Children's Memorial hospital, Chicago, spoke on "Human Relationships with Children."

Tea was served at a table gay with a spring bouquet of daffodils, freesia, and snapdragons. Yellow tapers burned in five-branch silver candelabra. Mrs. C. P. Doyle and Mrs. A. M. Campbell presided at the services.

Mrs. Fred Drolett, chairman, was assisted by Mrs. C. B. Gardner, Mrs. Fred Huntley, and Mrs. William Cameron.

Mrs. P. T. VanderZalm, president of the auxiliary, presided and Mrs. H. S. Bartholomew, program chairman, introduced the speaker.

MRS. P. C. STRAUSS,  
*Press Chairman*

### Eaton County

The Woman's Auxiliary met on January 27, at the home of Mrs. John Lawther for a pot-luck dinner. Eighteen members were present. Following a short business meeting, when it was decided to give specified maternity supplies to the Kellogg Foundation for distribution throughout the county, a baby shower was given for the five months old baby recently adopted by Dr. and Mrs. L. G. Sevenson of Charlotte.

MRS. B. P. BROWN,  
*Press Chairman*

### Jackson County

The January meeting of the Women's Auxiliary was held in the home of Mrs. W. L. Finton, Tuesday evening, January 18. Fifty-seven members were present. The dinner, which was prepared by the Homade Company, was in charge of the following committee—Mesdames R. M. Cooley and M. J. McLaughlin; co-chairmen, G. R. Bullen, C. E. DeMay, George C. Hardie and John W. Page.

At a short business meeting it was voted to undertake service projects for the two local hospitals. It was also suggested by the *Hygeia* Committee, and voted upon, to solicit *Hygeia* subscriptions from the physicians.

During the social hour, Mrs. Myron Susskind conducted a "Professor Quiz" contest. Later bridge was played.

ANNA HYDE SHAEFFER,  
*Press Chairman*

### Kalamazoo County

A most enjoyable meeting of the Woman's Auxiliary was held at the home of Mrs. W. W. Lang on January 18, 1938.

After a coöperative dinner Mrs. William McKinley Robinson charmingly entertained us with a talk on her recent trip to the Orient. Mrs. Robinson compared the characteristics and mode of living of the Japanese with the Chinese which was most interesting and instructive.

A brief business meeting followed. Mrs. R. W. Shook reported that our gifts to the old people at Christmas had been gratefully acknowledged and Mrs. W. D. Irwin stated that the tuition of the deaf child had been paid to the Harding School.

Thirty-six members and four guests were present.

(Mrs. Hugo) BARBARA K. AACH,  
*Publicity Chairman*

### Kent County

The Woman's Auxiliary met in the afternoon of January 12, in the club rooms of the society. Mrs. J. B. Whinery was the speaker of the afternoon, using as her topic "My Impressions of Russia." Mrs. E. S. Sevensma and Mrs. H. C. Swenson were the hostesses in charge of the tea served after the meeting.

Mrs. F. A. Votey is preparing an article for the



year book of the Federation of Garden Clubs on "Marijuana." She is chairman of the conservation committee for the Federation of Garden Clubs.

The *Hygeia* Committee, Mrs. Wm. Butler, chairman, worked hard to make every member of the auxiliary a subscriber to *Hygeia* before the end of January. They succeeded in lining up 101 subscriptions out of a possible 110.

We are looking forward with interest to the meeting February 9, when Dr. John Lavan will speak on "Food Handling Facts."

(Mrs. Robert) MIRIAM ADAMS EATON

#### Monroe County

The Woman's Auxiliary held a dinner and business meeting at the Monroe Country Club on January 20. Plans were made for a Valentine Bingo Party at which the members of the Medical Society are to be our guests.

A social hour followed.

(MRS. VINCENT) MARTHA BARKER,  
*Press Chairman*

#### Saginaw County

Thirty-eight members of the auxiliary met January 18, at the home of Mrs. Victor L. Hill, to hear Chester E. Miller speak on school needs. Mrs. L. C. Harvie presided. Later bridge was enjoyed.

MRS. A. E. LEITCH,  
*Press Chairman*

### Among Our Contributors

**Dr. S. Stephen Bohn** was graduated from the University of Michigan Medical School in 1933. He served his internship at St. Joseph's Mercy Hospital, Ann Arbor, and he spent one year as house physician at Mercywood Sanitarium, Ann Arbor. He took a two-year training course at the Neurological Institute of New York after which he received the degree of Doctor of Medical Science in Neurology from Columbia University. Dr. Bohn is on the outpatient staff of Harper and Receiving Hospitals, Detroit. His practice is confined to neuropsychiatry.

\* \* \*

**Dr. O. S. Brines** is Assistant Professor of Pathology at Wayne University and Pathologist at Receiving Hospital, Detroit. He is Chairman of the Cancer Committee of the Michigan State Medical Society.

\* \* \*

**Dr. L. C. Grosh, Jr.**, was graduated from the Johns Hopkins Medical School in 1930. He served as instructor in the Department of Medicine, University of Michigan Medical School, 1932 to 1934. He has been Assistant Physician at the Ypsilanti State Hospital, Department of Research since 1935.

\* \* \*

**Dr. George P. Reynolds** was graduated with the degree of A.B. from Harvard University in 1920 and M.D. in 1924. His practice is limited to internal medicine. Dr. Reynolds is instructor in medicine, Harvard Medical School, Junior Visiting Physician of the Boston City Hospital.

\* \* \*

**Dr. Loren Shaffer** is Chairman of the Advisory Committee on Syphilis Control of the Michigan State Medical Society, Director of the Social Hygiene Division, Detroit Department of Health, and Professor of Dermatology and Syphilology, Wayne University, College of Medicine, Detroit.

### MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

#### DR. GUDAKUNST OUTLINES PROGRAM

Four conditions which must be met by the health and medical agencies of Michigan in a long-range program to improve the health of the citizens of this state were outlined by Dr. Don W. Gudakunst on February 1 when he assumed his office as State Commissioner of Health.

To adequately conserve and promote the health of the people, said Dr. Gudakunst:

"(1) There must be a general knowledge of the need and value of medical services in times of health as well as sickness; (2) there must be adequate and competent medical services readily available; (3) there must be both social and mechanical facilities for providing medical care; and (4) provision must be made for payment for these services dependent upon the economic status of the recipient.

"If these four requirements were fully met throughout the state, there would be but a minimum expenditure for care of the handicapped and permanently incapacitated. Public health would be raised to the highest level imposed by the hereditary limit of the people.

"Education of the people in respect to medical care must be directed to the intelligence levels of the various groups in the community. We must reach not only the intelligent but those whose thinking processes are slow or who are prejudiced through lack of training. This will call for the closest coöperation between educational leaders and health specialists.

"One of the functions of the health department is to extract the usable information from the mass of scientific data available and then to pass this on to patients and physicians alike. Fads, fancies, foibles come and go. These must be separated from the sound.

"Postgraduate education in medicine is recognized by all as an absolutely essential need. The physicians coming from our schools must be kept up to date. It is the function of the health department to aid the medical schools and the state and county medical societies in their programs of education. Physicians, as others, cannot all be reached entirely by mass action. There is a great need for individual contact of and discussion with practicing physicians relative to preventive medical services. This may well be done by the State Department of Health.

"Undergraduate medical education can and must be improved along many lines. Today the clinical teaching is excellent in most respects, but the social and public health aspects of sickness have not been stressed in medical schools. A great opportunity is afforded the State Health Department to aid in supplying a more adequate training aimed at meeting the new problems.

"While there are many counties with full-time health departments, there are still 25 counties not so served. These are, for the most part, in the more densely settled areas. There is an inadequacy of hospital care and there is an unequal distribution of medical men. The county hospitals are today so organized that they largely serve to care for only the end-results of lack of adequate medical care—they are not prepared to render medical services



when such would be most efficient and least expensive.

"Medical care costs money. Within certain limits not only public health but individual health is purchasable and is always worth paying for. If an individual cannot pay for his own medical care then that individual is very likely to become a welfare charge of the state. There is a vicious circle between poverty and disease—each contributing to and speeding the other. In the interest of public health and economy, this circle must be broken. It is the task of the State Department of Health, the foundations developed for health promotion, and the organizations of practicing professional people to devise some way for giving medical service to those who are not now getting it.

"This program is not for government alone—but for all the people of the state. It is not to be put into effect without additional funds made freely available by the people. Such spending must be done, but it will yield the greatest financial returns of any public investment. For a time we must pay for the neglect of the past and must add to this cost the price of prevention. This will eliminate a large part of the cost of caring for the destitute, chronic sick.

"This is a long time program measured in terms of generations—not merely weeks or months."

#### HEALTH WORKERS' TRAINING CENTER

Practical field training of public health personnel will become a reality under the coöperative training center which is being established in conjunction with the recently created Ingham County Health Department, according to Dr. Don W. Gudakunst, state health commissioner.

The new training center will enable selected graduates from academic public health courses to become familiar with rural health practices in the field. The training center will provide Michigan with a constant supply of experienced public health personnel. Health officers, sanitary officers and public health nurses will be given training extending over various periods from three months to a year under the supervision of well-qualified instructors.

While primarily a health department, the local health unit will operate the training center as an additional function in coöperation with the University of Michigan and the Michigan Department of Health. The personnel of the Ingham County Health Department will include a director, an assistant director, a supervising nurse and five public health nurses, a chief sanitary inspector and one assistant, a chief statistical clerk and an assistant. Selected students, upon completion of their academic public health studies, will be awarded scholarships at the training center and will carry on actual health work under the direction of the department personnel.

The Ingham County Health Department offers a unique example of coöperative endeavor in the promotion of local health protection. With a total budget of \$34,600, the new unit will receive \$11,100 from local appropriations, \$3,000 under state law from the Michigan Department of Health and \$4,500 from the Social Security funds allotted to the U. S. Public Health Service.

The Children's Fund of Michigan has allotted \$10,000 for the maintenance of the training facilities and an additional \$6,000 will come from the maternal and child health funds administered by the Michigan Department of Health.

#### MATERNAL AND CHILD HEALTH CONFERENCE

Michigan's program for the promotion of maternal and child health during the past 21 months since Social Security funds became available was reviewed by the 32 representatives of major health and welfare agencies meeting at Lansing, January 26 for the second annual conference of the General Advisory Committee on Maternal and Child Health, sponsored by the Michigan Department of Health.

Dr. Lillian R. Smith, director of the department's Bureau of Maternal and Child Health, presided at the conference and outlined the work which has been carried on with the aid of an annual federal allotment of approximately \$100,000. In all cases, said Dr. Smith, local programs are carried on with the advice and coöperation of the county medical societies.

The scope of the program outlined by Dr. Smith included child care classes in the rural schools of 33 counties, women's classes in 26 counties, maternal and child health nursing services in 13 counties, maternity nursing service in 11 counties, a demonstration maternity nursing service in St. Clair County, a home delivery nursing service in Cass County, refresher courses for physicians in 13 counties, nutrition institutes in 18 counties, the production of an educational film on prenatal care for showing before lay audiences, and the postgraduate training of public health nurses.

The conference representatives were welcomed by Dr. Don W. Gudakunst, State Health Commissioner, who declared "We all have our ideas of what should be done and it is through meetings such as this that we can exchange ideas, formulate a program, and, what is more important, carry that program into the field and put it into operation."

Dr. Alexander M. Campbell, acting chairman of the Advisory Committee, reported as follows: "As chairman of the Committee on Maternal Health for the State Medical Society, I wish to say that our relations with the Michigan Department of Health, the University of Michigan, and with the State Society have been very pleasant and very coöperative. You might be interested to know something about the activities in which we engaged.

"Through the coöperation of these agencies and a program outlined by Dr. Smith, I gave a five weeks' course in obstetrics in the northern part of the Lower Peninsular. In every case I met with a great deal of enthusiasm. I met with some opposition at first because they thought there might be some politics behind it, but when they understood, we were received cordially. In the whole five weeks, nothing unpleasant occurred. There is no question but what the physicians of the state are deeply interested in improving the quality of their obstetrics."

Dr. Henry Cook, president of the State Medical Society, expressed the consensus of the group when he proposed the coördination of all branches of preventive medicine in order that "we may help each other more and help the whole group." He said that interest in preventive medicine is growing rapidly among physicians and that the society is willing to coöperate in a coördinated program to improve maternal and child health.

The place that maternal and child health problems have occupied in the extra-mural teaching program of the University of Michigan was discussed by Dr. James D. Bruce, vice president and director of postgraduate medicine. Dr. Bruce declared that the University would be delighted to devote one day to maternal welfare and one day to child wel-



fare out of the eight-day postgraduate program offered physicians.

In commending the Joint Committee on Health Education with its twenty-five member agencies as an excellent medium for coordinating health education programs, Dr. Bruce declared, "Your maternal and child welfare programs must of necessity reach the people of the state, their mothers and children. It must teach every group as well as the professional group. If we do not get that consciousness of health over to lay groups, the best possible provision on the part of the doctors will not meet the situation. And, on the other hand, the greatest appreciation of good medical service on the part of the public will be of very little value unless you have a profession prepared to meet that need. There is in the Joint Committee a group of agencies which will permit the widest possible dissemination of health knowledge."

An immunization schedule which has been tentatively approved by the Michigan Department of Health, the State Medical Society and the Michigan Branch, American Academy of Pediatrics, was presented by Dr. F. B. Miner of Flint, representing the Academy. This immunization schedule is as follows: 3-6 months—Pertussis for whooping cough; 9 months—Diphtheria immunization; 12 months—Smallpox vaccination; 15 months—Schick test; Tuberculin tests recommended at 3, 6, 9, 12, and 15 years; and use of iodized salt is advised.

Organizations represented at the conference included the Michigan State Medical Society, Michigan State Dental Society, State Nurses' Association, Children's Fund of Michigan, W. K. Kellogg Foundation, Michigan State College, State Welfare Department, State Department of Public Instruction, Michigan League of Women Voters, the Maccabees, Daughters of the American Revolution, Michigan Child Study Association, Michigan State and National Grange, American Academy of Pediatrics, Michigan Crippled Children Commission, University of Michigan, State Organization for Public Health Nursing, and the Michigan Department of Health.

#### ROUTINE GROUP LABORATORY EXAMINATIONS LIMITED

Local health officers have been notified by the Michigan Department of Health that routine group laboratory examinations of specimens from food handlers and industrial workers will not hereafter be done by the Department laboratories at State expense.

The Department, however, does not wish to disparage the value of individual patient studies. Requests for routine laboratory examinations of food handlers and industrial workers have increased to such an extent that if all requests were granted the basic functions of the laboratories would be seriously handicapped. Routine laboratory examinations of specimens from food handlers do not help in the control of communicable diseases and similar examinations of specimens from industrial workers are of little public health significance, the Department pointed out.

The laboratories of the Michigan Department of Health function basically as an aid to physicians and health officers in the diagnosis and control of communicable diseases and the maintenance of a high standard of environmental sanitation. Current demands on the laboratories for these fundamental examinations are taxing the available facilities to the limit. If specific problems concerning group examinations arise, however, the Department will be glad to confer with local health officials regarding satisfactory methods of solution.

#### COMMUNICABLE DISEASE REVIEW FOR 1937

The incidence of tuberculosis, diphtheria, scarlet fever, measles, smallpox, poliomyelitis, syphilis and gonorrhea for 1937, according to reported cases, exceeded that of 1936. Those diseases in which the reported number of cases was less than for the preceding year were pneumonia, typhoid fever, whooping cough and meningococcic meningitis. Consideration of the communicable disease situation does not lead us to the conclusion that the incidence in all cases was increased to the extent that the figures would indicate.

A total of 6,469 cases of tuberculosis was reported for 1937 which is an increase of 1,312 over 1936. This, in reality, is an indication of a better degree of public health work. More cases were discovered by physicians and more cases were reported. It is believed that there was no increase in the actual number of cases occurring. Although figures for the twelve months are not complete as to the number of deaths, mortality for the first eleven months of the year increased from 1,938 in 1936 to 1,965 in 1937.

As stated in previous issues, it is evident that there has been a genuine increase in the incidence of diphtheria. The final figure for the year was 842 reported cases as compared to 661 for 1936. All evidence at hand indicates that it is the lack of immunization which makes possible such increases. Cases are occurring very largely in those who have never had active immunization.

The greatest increase in incidence in any disease is in scarlet fever. The final number of cases for 1937 was 24,798 as compared to 12,650 for the previous year. The number for 1937 exceeds by more than 5,000 that of any other year on record. Part of this increase is undoubtedly due to better diagnosis, discovery of more mild cases, and better reporting. But unquestionably there was a high incidence for the year.

The total number of reported measles cases for 1937 was 6,154 as compared to 2,453 for 1936. The incidence in 1936 is the lowest on record. The increase in 1937 was to be expected. It occurred principally in the latter months of the year and was in reality the beginning of the rise in the anticipated outbreak of 1938.

The increase in smallpox has been referred to in former issues of the JOURNAL. The final total of reported cases was 152. The larger part of these were definitely traced to one outbreak originating in Dundee. There were only 32 cases reported in 1936, the lowest year on record. At the present time there is some evidence of smallpox appearing in other parts of the state, particularly in the western part of the Upper Peninsula. Smallpox is not an extinct disease and doctors generally should be on the alert for it.

The increased incidence in poliomyelitis for 1937 received a great deal of publicity. The total number of cases reported was 421, which is almost three times the number reported in 1936. However, there have been several years during the last generation in which the number of reported cases has exceeded that for 1937.

The total number of cases of syphilis reported for 1937 was 8,708 as compared to 6,401 for 1936, and for gonorrhea, 7,072 cases in 1937 compared to 6,460 in 1936. These increases are, undoubtedly, due to the focusing of attention by the public and medical profession on venereal diseases and the importance of their control. In other words, it is due to better reporting brought about by publicity which is a part

*(Continued on page 282)*



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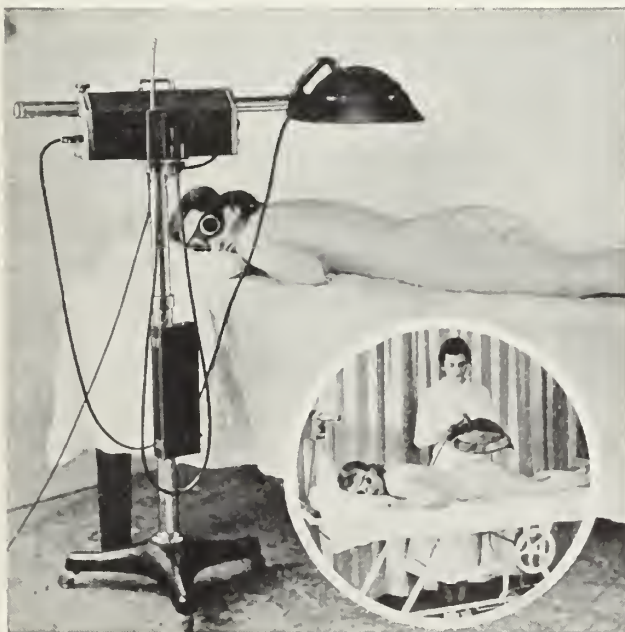
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**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technique with practice on living tissue; Clinical Course; Special Courses.

**GYNECOLOGY**—Two Weeks Intensive Course starting March 28; Personal Courses.

**OBSTETRICS**—Two Weeks Intensive Course starting April 11; Informal Course.

**FRACTURES & TRAUMATIC SURGERY**—Informal Practical Course; Ten Day Intensive Course starting April 11.

**OTOLARYNGOLOGY**—Two Weeks Intensive Course starting April 4.

**OPHTHALMOLOGY**—Two Weeks Intensive Course starting April 18; Personal Course in Refraction.

**UROLOGY**—General Course One Month; Intensive Course Two Weeks; Special Courses.

**CYSTOSCOPY**—Ten Day Practical Course.

**GENERAL, INTENSIVE AND SPECIAL COURSES IN ALL BRANCHES OF MEDICINE AND SURGERY.**

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of Cook County Hospital

### ADDRESS:

Registrar, 427 South Honore Street, Chicago, Ill.

(Continued from Page 280)

of the revived control program. It represents a small part of the total cases actually occurring and is, we believe, only the beginning of a much larger and more complete reporting which is a necessary part of any successful control program.

### SMALLPOX IN THE UPPER PENINSULA

Smallpox has been rather prevalent in Gogebic County during recent months and is now beginning to appear in other parts of the Upper Peninsula. The first four cases of this outbreak to be officially reported were from Bessemer in November, 1937. During succeeding weeks, cases were reported as follows:

Place	No. Cases	Date Reported
Wakefield, Gogebic County.....	1	1-13-38
Watersmeet Twp., Gogebic County....	1	1-13-38
Houghton Village, Houghton County..	2	1-17-38
Bergland Village, Ontonagon County..	1	1-19-38
Houghton Village, Houghton County..	1	1-21-38
Bessemer, Gogebic County.....	1	1-21-38
Bergland Village, Ontonagon County..	3	1-24-38
Ontonagon County .....	2	1-31-38

In spite of the fact that only a few cases were being reported during November and December and January, rumors persisted that smallpox was quite prevalent. Therefore, a field epidemiologist was sent from the Department to investigate. It was then discovered that there had been an epidemic in Wakefield for some time past and that perhaps there had been several scores of mild cases which were missed either because of not having medical attention or the diagnosis was not properly made. One such individual was on the federal jury at Marquette during January and became ill during his last day of service. Other men on the jury came from various parts of the Upper Peninsula.

It is only the high percentage of vaccinated people residing in the towns of the western part of Gogebic County that has thus far prevented smallpox from becoming extensive. It is apt to spread to other communities and become an even greater menace if such communities are not well vaccinated.

### INGHAM AND MUSKEGON COUNTIES TO ORGANIZE HEALTH DEPARTMENTS

Ingham and Muskegon counties will organize full-time county health departments following favorable votes of their respective boards of supervisors in January. The addition of these two populous counties will make a total of 58 of Michigan's 83 counties now provided with full-time local health departments.

### IN MEMORIAM

Dr. Samuel R. Turner

Dr. Samuel R. Turner, of Michigan Center, died on February 7, 1938, following a stroke. Dr. Turner was born at Freeport, Illinois, in 1858. He was graduated from the University of Louisville Medical School in 1888 and began his practice at Dyer, Indiana. He moved to Bronson, Michigan, in 1904 and in 1923 located in Michigan Center. Dr. Turner was a past-president of the Branch County Medical Society. He is survived by his wife, three married daughters and a son, Dr. Harold B. Turner, who is a practicing physician in Bloomfield, Indiana.

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## ◆ General News and Announcements ◆

### *The One Hundred Per Cent Club of the Michigan State Medical Society*

1. Ingham County Medical Society
2. Luce County Medical Society
3. Muskegon County Medical Society
4. Newaygo County Medical Society
5. Oceana County Medical Society
6. Ontonagon County Medical Society
7. Shiawassee County Medical Society

These county medical societies are the first to record 100 per cent paid membership for the year 1938. Dues for 1938 are now payable and are being received daily from the various county medical society secretaries. See your County Secretary today and help your Society become one of the first members of the "One Hundred Per Cent Club for 1938."

*The St. Joseph and Branch County Medical Societies* are planning a "State Society Night" which will be held at Sturgis in April.

*Past-President Henry E. Perry* is sojourning in Lakeland, Florida. His address is 202 Paloma Avenue, Lakeland. He reports that he is in the best of health and spirits.

For hotel reservations in San Francisco for the A.M.A. meeting, write Dr. F. C. Warnshuis, 450 Sutter Street, San Francisco. Give the names of members of your party, type of accommodations desired, rates, dates of arrival and departure.

*Dr. E. D. Busby*, Associate Professor of Surgery, University of Western Ontario, gave a talk on the subject of "Haematuria" before the members of the Genesee County Medical Society at its meeting of February 2, 1938.

\* \* \*

*The Committee on Scientific Work* of the Michigan State Medical Society held a meeting at the Olds Hotel, Lansing, on February 20, to develop the scientific program and presentations for the 1938 annual meeting, in Detroit, September 20, 21, 22.

\* \* \*

*Dr. Mary Margaret Fraser* of Detroit and *Dr. Lillian Smith* of Lansing were elected president and secretary, respectively, of the Michigan Branch of the National Women's Medical Association at their annual meeting in Grand Rapids last September.

\* \* \*

*I. M. Wieder*, of the National Discount & Audit Company, announces the appointment of M. G. Sweitzer of Lansing as representative in Michigan outside of Wayne County. Mr. Sweitzer will maintain an office at 800 American State Bank Bldg., Lansing.

\* \* \*

*Dr. Frank A. Kelly* of Detroit has been elected chief of the surgical staff of Grace Hospital. Dr. Charles S. Kennedy was named vice-chief. Doctor Kelly is a past-president of the Wayne County Medical Society.

Dr. Kelly addressed the Honolulu Medical Society on March 3. His subject was "The Injection Treatment of Hernia."

## In Congestive Heart Failure



# Theocalcin

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To diminish dyspnea, reduce edema and increase the efficiency of the heart action, prescribe Theocalcin in doses of 1 to 3 tablets, t. i. d., with meals. It acts as a potent diuretic and myocardial stimulant.

Tablets 7½ grains each,  
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65 cc. emulsified with 0.4 Gm. agar  
in a menstruum to make 100 cc.*



### *Have You Moved?*

It is important that the mailing list of THE JOURNAL of the M.S.M.S. be kept up to date and accurate. Members are invited to help THE JOURNAL in this work. When and if you change your mailing address, please drop a card to THE JOURNAL, giving your new address. If you would like to have your copy of THE JOURNAL sent to your home instead of your office (or vice versa), write the Executive Office, 2020 Olds Tower, Lansing. Please submit changes in address promptly to assist THE JOURNAL in avoiding delay in making mailing list revisions. We desire to have THE JOURNAL reach you each month without delay.

Dr. W. G. Maddock of Ann Arbor gave a demonstrative lecture on the roadside care of the injured preparatory for transportation to the hospital, before the members of the Hillsdale County Medical Society at its meeting held in Hillsdale on February 17.

\* \* \*

The Cleveland Academy of Medicine has adopted the principle that applications for membership from physicians who are graduates of foreign universities and who have been residents of this country only a short time shall be tabled automatically for two years.

\* \* \*

Dr. James D. Bruce, Director, Department of Postgraduate Medicine of the University of Michigan, presented a paper entitled "Continuing Professional Education" at the Thirty-fourth Annual Congress on Medical Education and Licensure held in the Palmer House, Chicago, on February 14 and 15.

\* \* \*

Dr. P. R. Urmston and Dr. L. Fernald Foster of Bay City were guests of the Huron-Sanilac County Medical Society at its meeting on January 25, at Marlette. Doctors Urmston and Foster discussed the activities of the Michigan State Medical Society.

\* \* \*

Dr. S. W. Donaldson of Ann Arbor has been appointed by President Henry Cook as a member of the Liaison Committee with the State Bar of Michigan, and also by The Council as a member of the Executive Board, Medical Defense for the coming year.

\* \* \*

The annual dinner dance of the Wayne County Medical Society was held at the Detroit Golf Club on February 26. This social evening is always a pleasant and enjoyable function, attended by hundreds of members and their guests. Details were arranged by the Entertainment Committee of the Society.

\* \* \*

"Does your firm advertise in The Journal of the Michigan State Medical Society and does it exhibit at the annual conventions of the M.S.M.S.?" Ask this question of all detail men who seek your business.

Those firms which you patronize should in turn support you.

\* \* \*

The Bay County Medical Society adopted a resolution whereby the Society decided to devote one of its two meetings each month to the transac-



tion of business and the other to general sociability. The volume of society business has increased to such an extent that it requires the time of a whole meeting.

\* \* \*

Dr. Robert S. Breakey of Lansing spoke at a public meeting in Bay City on the subject of "Syphilis," on February 9. The meeting was sponsored by the Woman's Auxiliary of the Bay County Medical Society and was held at the Nurse's Home, Mercy Hospital. He also addressed 1,500 high school children on "Keeping Fit."

\* \* \*

The Third Annual Postgraduate Institute, offering an intensive and interesting study of the Diseases of the Digestive Tract, will be conducted by the Philadelphia County Medical Society from March 28 to April 1, inclusive, in the Bellevue-Stratford Hotel, Philadelphia. Information may be secured from the Philadelphia County Medical Society, 21st and Spruce Streets, Philadelphia, Pennsylvania.

\* \* \*

The Wayne County Medical Society has issued a small sticker listing the various radio programs sponsored by national, state and county medical organizations, which are carried by Detroit radio stations. These announcements are being distributed to the membership of the W.C.M.S. with the suggestion that one be attached to statements and correspondence going to patients. The sticker is entitled "Medicine . . . on the air."

\* \* \*

Speakers on scientific subjects are available for county medical societies. Write the Executive Office, 2020 Olds Tower, Lansing, for talks on:

Cancer  
Maternal Health  
Mental Hygiene  
Syphilis  
Tuberculosis  
Preventive Medicine  
Social Aspects of Sickness  
Occupational Diseases.

\* \* \*

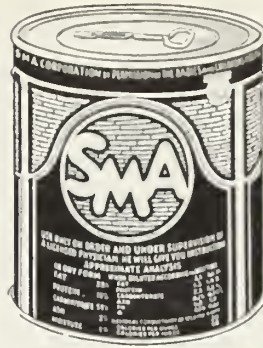
Dr. J. D. Brook of Grandville, one of Michigan's delegates to the American Medical Association House of Delegates, has been honored by being selected as a member of the first Committee on Distinguished Service Awards of the A.M.A., a five-man board. This committee is authorized to receive nominations for the award, to be given annually on the basis of meritorious service in the art and science of medicine. The award will include a distinguished service medal and a citation.

\* \* \*

Acting Comptroller-General Elliott has declared illegal the group medical plan for employees of the Home Owners Loan Corporation, Washington, D. C., financed by \$40,000 of Federal funds, and known as "Group Health Association, Inc." Because of the special status of the HOLC, the opinion is viewed as purely advisory. However, the Association has requested the courts to adjudicate the matter. As yet, this important case has not been heard.

\* \* \*

The Michigan Society for Mental Hygiene will meet at the Hotel Statler on April 7 and 8. There will be a special meeting on April 7 to which the medical profession are cordially invited. This meeting will be addressed by Dr. Harry Stack Sullivan of New York City. He is a member of the faculty of the Washington, D. C., School of Psychiatrists and president of the William A. White Psychiatric Foundation, New York. Dr. Sullivan's subject will be "The Application of Principles of Mental Hygiene to the Practice of Medicine."



## What have you to gain by prescribing S.M.A.?

In feeding infants deprived of breast milk, you have available a number of products capable of producing apparently satisfactory results. Why, then, should you choose S. M. A.?

Here are advantages thousands of physicians have found in prescribing S. M. A.—

- S. M. A. produces excellent nutritional results simply and quickly.
- S. M. A. is simple to prescribe and simple for the mother to prepare. You both save time and avoid exacting detail.
- S. M. A. is antirachitic and antispasmodic. An ample quantity of cod liver oil has always been included in S. M. A. making it unnecessary to prescribe additional vitamin D activity.
- S. M. A. is produced from tuberculin-tested cows' milk, under laboratory control, by a firm of nutritional specialists.

Convince yourself. Prescribe S. M. A. and compare the results with your present methods. You will find, as have thousands of other physicians, that S. M. A. offers added advantages to you, to the mother, and to the infant.

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*Under the Crippled and Afflicted Child Laws, what fee is paid to physicians for calls made on hospital cases after the fifteenth day limitation has expired (such as for appendectomies)?*

Answer: A fee of \$1.50 per day, after the fifteenth day limitation, is paid to the physician who makes a call or calls on the patient in the hospital. Please note that the physician who calls at the hospital once a day is paid \$1.50; if it is necessary for him to call two, three or more times the same day, he is paid \$1.50 per day—not per call.

\* \* \*

The American Board of Ophthalmology announces that it will hold examinations during 1938 in the following cities: San Francisco, June 13, during the A.M.A. Convention; in Washington, D. C., October 8, during the meeting of the American Academy of O. and O.L.; in Oklahoma City, November 14, during the meeting of the Southern Medical Association.

Any graduate or undergraduate of an approved medical school may make application for membership in this group. Application blanks may be secured from Dr. John Green, Secretary, 3720 Washington Avenue, St. Louis, Mo.

\* \* \*

The "sleeping potions" of an earlier day were often linked with evil doing, and plants having hypnotic powers were regarded with superstitious fear. Shakespeare mentions the shriek which was said to emanate from the mandrake (mandragora officinarum) as its roots were torn from the earth and which caused all mortals who heard to run mad. Hypnotic drugs, now thoroughly understood, have become an integral part of modern therapy. Quiet, restful sleep is procurable through the use of "Amytal" (Iso-amyl Ethyl Barbituric Acid, Lilly), and the drug is given with a feeling of safety based upon its broad background of clinical use.

\* \* \*

Dr. C. E. Umphrey, President of the Wayne County Medical Society, has developed a new and very attractive format for his President's Monthly Letter. This four-leaved message contains timely notes on pertinent topics, and keeps the W.C.M.S. members informed of activities which are personal and confidential between physicians. President Umphrey's letters contain important information, attractively prepared.

"Everything you do to help the medical society, you do to help yourself," is one of the pithy statements in Dr. Umphrey's letter of February, 1938.

\* \* \*

The Ingham County Medical Society will hold its Annual Spring Clinic on April 28, 1938, at the Olds Hotel, Lansing. Speakers of national eminence will be heard on the afternoon and evening programs. Among them are Dr. James M. Pierce of Cincinnati; Dr. Frederick Christopher of Evanson; Dr. H. G. Poncher of Chicago, and Dr. Frederick A. Coller of Ann Arbor. The afternoon session will begin promptly at 2:00 p.m. and dinner will be served at 7:00 p.m. followed by the evening lecture. All members of the Michigan State Medical Society are cordially invited to attend this one-day clinic.

\* \* \*

Help W.P.A. pay you promptly.—It is the aim of the United States Employees' Compensation Commission and of the Michigan Works Progress Administration to make payment of vouchers for medical treatment rendered to injured W.P.A. employees with as little delay as possible. Physicians are urged to help W.P.A. officials in their attempt to help the physicians by having readily available full

information regarding treatment so that time consumed in the preparation of necessary medical reports and vouchers will be minimized. Be sure to keep accurate records—for your own protection. The above applies to compensation work only.

\* \* \*

*Michigan State Medical Society Placement Service.*—The following communities desire a Doctor of Medicine, according to requests addressed to the Michigan State Medical Society:

Town	County	Size (Census in 1930)
Coral	Montcalm	350
Three Oaks	Berrien	1,336
Carsonville	Sanilac	444
Lawton	Van Buren	1,164
Argyle	Sanilac	200
Gladwin	Gladwin	1,248
Rose City	Ogemaw	338
Mio	Oscoda	350
Onondaga	Ingham	220

\* \* \*

*Under a system of socialized medicine,* the patient will lose the advantages of the confidential patient-family physician relationship wherein the individual needs of every person are recognized. If ever a human being wants to be an individual, it is when he is sick!

The patient knows that free choice of physician must be restricted under a program of socialized medicine, as the leading physicians with more independence will not become part of a socialized medicine scheme. This has been the experience abroad. Medical attention will become a mechanical system rather than a personal service. Mass production methods will be used.

The patient does not want inferior *quality* of medical service.

\* \* \*

*Listed below* are the names of some more of your friends who entered technical exhibits at the Grand Rapids Convention of the Michigan State Medical Society in 1937. The products of these firms are Council approved, where indicated, and are worthy of your consideration:

M & R Dietetic Laboratories, Inc., Columbus, Ohio.  
McIntosh Electrical Corporation, Chicago, Illinois.  
Mead Johnson & Company, Inc., Evansville, Indiana.  
Medical Arts Surgical Supply Co., Grand Rapids, Michigan.  
Medical Case History Bureau, New York City.  
The Medical Protective Company, Wheaton, Illinois.  
Merck & Co., Inc., Rahway, New Jersey.  
The Wm. S. Merrell Company, Cincinnati, Ohio.  
Michigan Branch, American Pharmaceutical Association, Detroit, Michigan.  
Middlewest Instrument Company, Chicago, Ill.

\* \* \*

*Dr. Loren W. Shaffer,* chairman of the Syphilis Control Committee of the Michigan State Medical Society, has arranged, through the Joint Committee on Health Education, to visit every county medical society in the Upper Peninsula during the last week of March. Dr. Shaffer will present the pertinent facts of the syphilis control program of the Michigan State Medical Society in coöperation with the State Department of Health to practicing physicians and to health officers. He will be accompanied by Dr. Clare Gates, Field Secretary of the Joint Committee on Health Education, who will contact and speak to many lay agencies along the route of some sixteen hundred miles.

The itinerary is as follows:

Monday, March 28—Manistique and Escanaba (noon and night); Tuesday, March 29—Menominee and Iron Mountain (noon and night); Wednesday, March 30—Ironwood and Houghton (noon and night); Thursday, March 31—Ontonagon and Marquette (noon and night); Friday, April 1—Newberry and Sault Ste. Marie (noon and night).

MARCH, 1938

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EXCLUSIVELY for the TREATMENT  
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ACUTE and CHRONIC ALCOHOLISM

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carry more than 50,000 policies in these Associations whose membership is strictly limited to Physicians, Surgeons and Dentists. These Doctors save approximately 50% in the cost of their health and accident insurance.



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For the Care and Treatment of  
Nervous Diseases

Building Absolutely Fireproof

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### **C** All worth while laboratory examinations; including—

Tissue Diagnosis

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Intravenous Therapy with rest rooms for Patients.

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The pathologist in direction is recognized  
by the Council on Medical Education  
and Hospitals of the A. M. A.

Secretary of State George E. Saunders of Colorado has ruled that the initiative petition for an amendment to the constitution of Colorado developed and circulated by chiropractors is invalid for submission to the voters of the state at the coming election. The proposed amendment, if adopted, would have repealed the Basic Science Law, and made the Medical Practice Act ineffective, as well as most public health laws. In short, it would have taken away from the state the right to license any profession, which has been interpreted by competent lawyers to include law, medicine, dentistry, nursing, accountancy, engineering, architecture, optometry, pharmacy, veterinary medicine, etc., ad infinitum.

The decision of Secretary of State George E. Saunders was based on evidence obtained by the Colorado State Medical Society.

\* \* \*

*Pre-nuptial physical examination* legislation: (a) The Ohio State Medical Association, in coöperation with the Ohio Bar Association, has developed a pre-nuptial physical examination bill, similar to the Michigan law, for presentation to the Ohio legislature at its next regular session.

(b) The Conference of County Society Legislative Chairmen of the Medical Society of the State of New York, meeting in Albany on February 9, approved the Pre-nuptial Physical Examination Bill now being considered by the New York Assembly.

(c) At the Indiana State Medical Society Secretaries' Conference in Chicago, February 12, Chairman A. M. Mitchell of Terra Haute advised that the Indiana State Medical Association is developing a pre-nuptial physical examination law for presentation to the Indiana legislature in 1939.

\* \* \*

*The gratitude of the medical profession* and of the people of this state and country, is due the United States Congressional sub-committee which recently held hearings on the anti-vivisection bill (H.R. 3890).

The sub-committee decided to make an adverse report to the full Committee on the District of Columbia, which means that there is little chance of this pernicious measure being enacted into law by the present Congress of the United States.

Congressman Paul W. Shafer of the Third District of Michigan, whose residence is in Battle Creek, was an important member of this committee which felt that medical research would be retarded, if not destroyed, by enactment of any such measure as H.R. 3890.

Congratulations, Mr. Shafer, and thanks from a grateful public.

\* \* \*

### Kent County's "State Society Night"

A "State Society Night" was arranged by the Kent County Medical Society on February 9, in the Pantlind Hotel, Grand Rapids. The following State Society Officers were present: President Henry Cook, President-Elect Henry A. Luce, Secretary L. Fernald Foster, Treasurer Wm. A. Hyland, Councilors P. R. Urmston, A. S. Brunk, Vernor M. Moore, Henry R. Carstens, I. W. Greene, Past Speaker of the House Frank E. Reeder.

Brief addresses were given by Secretary Foster, Executive Secretary Burns, President-Elect Luce, President Cook, Finance Chairman Carstens, and by State Health Commissioner Don W. Gudakunst.

Arrangements were made by President A. J. Baker, Secretary John M. Whalen and Councilor Moore of the Kent County Medical Society. Over one hundred members of the Kent County Medical Society attended this very interesting and inspiring meeting.

*Crippled and Afflicted Child Commitments* for the months of December, 1937, and January, 1938, were as follows:

*December, 1937*

**Crippled Child:** Total of 228, of which 105 went to University Hospital, and 123 to miscellaneous hospitals. Of the above, Wayne County wrote 28 orders, of which two went to University Hospital and twenty-six went to miscellaneous hospitals.

**Afflicted Child:** Total of 1,477 of which 177 went to University Hospital, and 1,300 went to miscellaneous hospitals. Of the above, 312 were sent from Wayne County, of which nineteen went to University Hospital, and 293 went to miscellaneous hospitals.

*January, 1938*

**Crippled Child:** Total of 312, of which eighty-three went to University Hospital, and 229 went to miscellaneous hospitals. Of the above, Wayne County wrote 118 orders; five went to University Hospital and 113 went to miscellaneous hospitals.

**Afflicted Child:** Total cases, 1,498 of which 223 went to University Hospital, and 1,275 went to miscellaneous hospitals. Of the above 434 were sent from Wayne County, twenty-four going to University Hospital, and 410 to miscellaneous hospitals.

\* \* \*

**The Northern Tri-State Medical Association**

The Northern Tri-State Medical Association will hold its sixty-fifth annual meeting April 12, 1938, at Findlay, Ohio. The program is as follows: Dr. H. H. Cummings, Obstetrician and Gynecologist of Ann Arbor, Michigan, "Treatment of Fibromyoma of the Uterus"; Dr. Warren H. Cole, Professor of Surgery, University of Illinois, "Hyperthyroidism"; Dr. Douglas Donald, Assistant Professor of Clinical Medicine, Wayne University, Detroit, "Pain in

the Cardiac Area Not Due to Coronary Disease"; Dr. Charles Doan, Professor of Medicine, O. S. U., Columbus, Ohio, "The Myelophthitic Anemias"; Dr. Max Thorek, Surgeon, Chicago, Illinois, "Electrosurgical Obliteration of the Gall Bladder"; Dr. Irvin S. Cutter, Dean, Northwestern University Medical School, Chicago, "Therapeutics of Later Years of Life"; Dr. Daniel J. Davies, Assistant Professor of Obstetrics, University of Cincinnati, Ohio, "Hemorrhage in Pregnancy and Labor"; Dr. B. H. Nichols, Roentgenologist, Crile Clinic, Cleveland, Ohio, "Evaluation of X-ray Findings in Diseases of the Stomach and Gall Bladder"; Dr. Max Cutler of Michael Reese Hospital, Chicago, Illinois, "Indications and Limitations of Radiation in the Treatment of Cancer", and Dr. J. S. Speed, Professor of Orthopedics, University of Tennessee, "Central Fractures of the Neck of the Femur."

In the evening, there will be a banquet. The speakers will be Dr. Gilbert J. Thomas, President of the American Urological Association, Minneapolis, "Infections Other than Tuberculosis of the Urinary Tract: Diagnosis and Treatment," and Dr. Alan Brown, Professor of Pediatrics, University of Toronto, Ont., Canadian Gov., Consultant for Quintuplets, "A Consideration of Some Common Disturbances in Children Frequently Incorrectly Handled."

\* \* \*

**Medical Education**

**Herman Kiefer Hospital, Detroit**

Since 1930 Graduate Conferences for Physicians have been sponsored in Detroit jointly by the Wayne County Medical Society and the Detroit Department of Health. During this period there have been sixty-eight conferences, forty-three individual speakers and a total attendance of approximately 7,500. These conferences were devoted almost entirely to Preven-

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tive Medicine, and attendance at these meetings definitely indicates their value and the interest of the private physician in this field. In addition to these bi-annual conferences there are many other well-attended meetings held throughout the city every year devoted largely to Preventive Medicine.

### **1938 GRADUATE CONFERENCE FOR PHYSICIANS**

Herman Kiefer Hospital Auditorium

Detroit

Month of April Wednesday Mornings 10 to 12 o'clock

**ALL PHYSICIANS ARE INVITED**

#### **April 6**

10 A. M. "The Practicing Physician and Syphilis Control and Treatment"—Dr. John H. Stokes, University of Pennsylvania.

11 A. M. "Present Therapeutic Problems in the Control of Gonorrhea"—Dr. P. S. Pelouze, University of Pennsylvania.

#### **April 13**

10 A. M. "Pneumonia Control"—Dr. Jesse G. M. Bullowa, New York City.

11 A. M. "Serum Sickness"—Dr. Warren T. Vaughan, Richmond, Va.

#### **April 20**

10 A. M. "Evaluation of Present Immunization Methods"—Dr. LeRoy D. Fothergill, Harvard University.

11 A. M. "New Concepts and Developments of Treatment of Communicable Disease"—Dr. Edwin H. Place, City Hospital, Boston, Mass.

#### **April 27**

10 A. M. "The Mental Problems of the Adolescent"—Dr. William S. Sadler, Chicago, Ill.

11 A. M. "The Recognition and Treatment of the Early Case of Mental Illness"—Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C.

\* \* \*

### **Jackson County's "State Society Night"**

The Jackson County Medical Society, originator of Michigan's "State Society Nights," held its third annual event of this type on January 18, 1938, at the Hotel Hayes. The cocktail hour started at 5:30 P.M. and dinner was served in the ballroom promptly at 7:00 P.M.

The meeting was called to order by the president, Dr. John VanSchoick of Hanover, whose address of welcome was supplemented by similar remarks from Dr. A. W. Strom, vice president of the Hillsdale County Medical Society who joined the Jackson group this year as co-hosts for the evening.

Dr. H. H. Cummings of Ann Arbor, councilor of the 14th district, spoke on "Post-graduate Medicine." Dr. Martin H. Hoffmann of Eloise, vice speaker of the House of Delegates and chairman of the State Society membership Committee discussed "Much Ado About Something." Dr. Henry Cook of Flint, president of the M.S.M.S., spoke on "The Professional Background." Dr. A. G. Sheets, mayor of Eaton Rapids, and his inseparable companion, Dr. J. G. Bradley of Eaton Rapids, advisor to the Legislative Committee of the M.S.M.S., spoke extemporaneously. Dr. J. E. McIntyre of Lansing and Dr. Wilfrid Haughey of Battle Creek, councilors of the 2nd and 3rd districts respectively, made a few appropriate remarks.

## **—LEMONS—**

Select Lemons.....	75 lbs.	\$7.00
Select Limes.....	90 lbs.	8.00
Select Oranges.....	90 lbs.	5.00
Select Tangerines.....	90 lbs.	5.50
Select Grapefruit.....	90 lbs.	4.50

Strictly First Quality Fruit.

Much lower prices on Field run fruit. Best  
attention to the Physician.

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## GENERAL NEWS AND ANNOUNCEMENTS

The sergeant-at-Arms of the House of Delegates of the M.S.M.S., Dr. James John O'Meara, paid a very glowing tribute to the work of one of the Jackson members and then introduced this member who, strange as it may seem, turned out to be his brother-in-law, Dr. Philip A. Riley, who seems to have survived the relationship enough to have become Speaker of the M.S.M.S. House of Delegates in spite of this tremendous handicap. Dr. Riley gave a résumé of the work accomplished at the recent meeting of The Council of the M.S.M.S. in Detroit and the high lights of the plans for 1938.

Dr. W. L. Finton had the pleasure of introducing his son, Dr. Walter R. Finton, to the group at the young doctor's first meeting as a regular member of the society. This makes the second father-son combination at Jackson, the other being Dr. John C. Smith and his son, Dr. Dean Smith, who became a member last summer.

Telegrams of regrets were read by the secretary from Bill Burns (ill in the hospital), Drs. L. F. Foster, Grover C. Penberthy, Henry A. Luce and others.

The attendance from the two societies acting as hosts was nearly 100 per cent and a fine evening of friendship was enjoyed.

\* \* \*

*How to go to San Francisco Next June.*—Special trains and cruises to San Francisco for the 1938 meeting of the American Medical Association are being arranged, for the convenience of physicians and their ladies who plan on attending the Convention, June 13 to 17, 1938. We invite your attention to:

1. The "Golfers Special" of the American Medical Golfing Association, which includes an ocean voyage from New York to New Orleans (six days) on the S. S. Dixie, sailing June 1. Five games of golf will be played on excellent courses on the out-going trip, with stops and sight-seeing at Houston, Galveston, San Antonio, Los Angeles, and Del Monte.

The big A.M.G.A. Tournament will be held at the San Francisco Golf and Country Club on Monday, June 13. (36-hole competition).

### On the Way to San Francisco



## GOLFERS' SPECIAL TO 'FRISCO

for the A.M.A. Convention, June 13-17, 1938

New Orleans—Houston—Galveston—San Antonio—Los Angeles—Del Monte—San Francisco!  
Return thru Portland—Seattle—Vancouver—Lake Louise—Banff!

Nine Games of Golf—Sightseeing—Entertainment—a Day with Hollywood Stars

Non-golfers as well as golfers (and their ladies) invited.

### YOU OWE YOURSELF THIS WONDERFUL TRIP

Under sponsorship of the American Medical Golfing Association. For itinerary and further information drop a card to Dr. Walt P. Conaway, Pres., AMGA, 1723 Pacific Ave., Atlantic City, N. J.



The return journey will be through Portland, Seattle, Vancouver, Lake Louise and Banff, with two additional games of golf, more sight-seeing, and a steamship voyage up Puget Sound.

Non-golfers as well as golfers (and their ladies) are invited to take advantage of this unique trip.

Those not able to make the entire trip may take the "Golfers Special" on the out-going trip, or join it on the return journey. For further information write Bill Burns, 731 N. Capitol Avenue, Lansing, Michigan. (See announcement in this issue on page 291).

2. **The American Express Tour** starts officially in Chicago on June 6, and includes an exploration of the Indian Pueblo district, the Grand Canyon, Los Angeles, Riverside and Santa Catalina Island, on the way out to San Francisco. A choice of two return routes is possible, one of which visits the charming cities of Portland, Seattle, Victoria, Vancouver and the beautiful scenic spots of the Canadian Rockies; the second route, traveling through Yellowstone National Park (three and one-half days), and via Salt Lake City, Royal Gorge, Colorado Springs and Denver. For complete details write the American Express Travel Service, 723 Marquette Avenue, Minneapolis, Minn.

\* \* \*

### American College of Surgeons

The Great Lakes Sectional Meeting of the American College of Surgeons, including Ontario, Quebec, and the states of New York, Ohio, Michigan, and Pennsylvania, will be held in Toronto, Ontario, on March 22, 23, and 24. The headquarters will be at the Royal York Hotel. A most active Committee on Local Arrangements, headed by Dr. W. Edward Gallie, is making excellent plans for this meeting. There will be an exceptionally interesting program consisting of clinics, scientific sessions, hospital conferences, medical motion pictures, and other features during the meeting. A visiting group of ten or twelve outstanding surgeons will be present to participate in this program.

A general outline of the program is as follows:

#### *Tuesday, March 22*

- 8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
- 9:00-12:00—Operative and non-operative clinics, surgery and the surgical specialties, local hospitals.
- 10:00-12:30—Hospital conference.
- 2:00- 4:30—Hospital conference.
- 2:30- 4:30—Medical motion pictures:
  1. General surgery.
  2. Eye, ear, nose and throat surgery.
- 4:30- 5:00—Annual meeting, Fellows of the College.
- 6:30- 8:00—Medical motion pictures, general surgery.

- 8:00-10:00—Scientific meeting, general surgery.
- 8:00-10:00—Medical motion pictures, eye, ear, nose and throat surgery.
- 8:00-10:00—Hospital conference.

#### *Wednesday, March 23*

- 8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
- 9:00-12:00—Operative and non-operative clinics, surgery and the surgical specialties, local hospitals.
- 10:00-12:30—Hospital conference.
- 1:00- 2:00—Medical motion pictures, general surgery.
- 2:00- 5:00—Scientific meeting, general surgery.
- 2:00- 5:00—Scientific meeting, eye surgery.
- 2:00- 5:00—Scientific meeting, ear, nose and throat surgery.
- 2:00- 5:00—Hospital conference.
- 6:30- 8:00—Medical motion pictures, general surgery.
- 8:00-10:00—Scientific meeting, general surgery.
- 8:00-10:00—Scientific meeting, eye surgery.
- 8:00-10:00—Scientific meeting, ear, nose and throat surgery.
- 8:00-10:00—Motion pictures for hospital representatives.

#### *Thursday, March 24*

- 8:00- 9:00—Registration and general information for Fellows of the College, hospital representatives, and guests.
- 9:00-12:00—Fracture clinic.
- 9:00-12:00—Operative clinics, eye, ear, nose and throat surgery.
- 10:00-12:30—Hospital conference.
- 2:00- 5:00—Scientific meeting (panel round table conference), eye surgery.
- 2:00- 5:00—Scientific meeting (panel round table conference), ear, nose and throat surgery.
- 2:00- 5:00—Cancer clinic.
- 2:00- 5:00—Hospital conference.
- 8:00-10:00—Medical motion pictures, general surgery.
- 8:00-10:00—Community health meeting.

This meeting will be of interest not only to Fellows of the College but to the medical profession at large, as well as to hospital trustees, superintendents, nurses, and hospital personnel. Members of the State Medical Association are most cordially invited to attend. There will be no registration fee.

### German Baby Ban

The Nazi government, still determined to build a nation of physically superior citizens regardless of the cost, has instructed doctors that deformed or abnormal babies are not to be brought into the world. Strange as it sounds, reports come from extremely reliable sources that the German Health Ministry has issued a short, confidential memorandum to this effect to all practicing doctors. The memo added: "As a medical man, you will know how to prevent the child taking life, and what to explain to the mother."—*News Week*, Feb. 21, 1938.



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### THE MEDICAL PROFESSION VERSUS SYPHILIS\*

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Surgeon General, U.S.P.H.S.  
WASHINGTON, D. C.



Michigan, more than any other state in the Union, epitomizes this century's progress in the mechanical arts. As the nineteenth century waned, men found new means to annihilate distance. In your state men mastered the means to bring this new mobility to every citizen.

In rearing industry to its vigorous maturity Michigan fathered a revolution in American life. The migration of labor reached new proportions. Vacations became nomadic. The front parlor gave way to the automobile as the situs for courtship—and the front parlor disappeared from homes. Autoists demanded better roads; better automobiles

suggested still better roads. Standardization came; bigger industries became possible. Suburbs spread beyond the wildest imaginings of those sanguine city planners who built belt-line railroads in the '80's—built them at that point beyond which, their Spencerian sociology could demonstrate, no city could possibly grow. Wider environs raised city land values; higher land values raised skyscrapers; skyscraper congestion made subways necessary. . . . Technicological trends and the social problems of our new cities are challenging the best engineering, economic and governmental attention of the day.

There is something in Michigan's association with modern technology which makes it easier for me to approach this problem of syphilis. Medicine owes a great deal both to engineering and to research in this century. From the point of view of mechanical equipment, the modern hospital

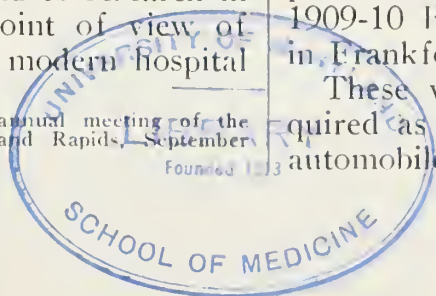
would astound the physician of 1890. Medical research and practice kept pace in this development. There is no branch of medicine that has been more greatly revolutionized than syphilology.

Syphilis in 1900 was listed among the "incurable" diseases. Doctors worked at it doggedly, but without serious expectation of doing the patient much good. In latency it could not be satisfactorily diagnosed. The organism, if organism there was, had not been discovered.

Then in the short space of ten years everything important happened. In Berlin, Schaudinn peered through the lens of his dark-field microscope and saw the spirochete. That was in 1905. Two years later the researches of Wassermann gave us the complement fixation test. Then in the winter of 1909-10 Ehrlich and his hectic researchers in Frankfort-on-Main discovered salvarsan.

These were rudimentary. Diagnosis required as much perfecting as did the first automobiles of Haynes or Ford. In the

\*Read before the seventy-second annual meeting of the Michigan State Medical Society, Grand Rapids, September 29, 1937.





hands of bad technicians, the complement fixation test could be an instrument of cruel injustice, rather than precision. Ehrlich, in his enthusiasm, thought that one injection of his arsenical would cure syphilis. But salvarsan proved to be toxic sometimes; relapses occurred, crazily, Ehrlich thought.

To a group of physicians it is hardly necessary to describe the difficult problem that faced the physician in making these new principles clinically effective. With the shattering of Ehrlich's one-dose utopia, there came a problem of discovering in what dosages and scheme of treatment the arsenicals could be administered effectively. In countless hospitals and clinics, in hundreds of doctors' offices, that problem was to remain acute for more than a quarter of a century. The relative effectiveness of different drugs in each stage of syphilis similarly was in dispute. Refinements of the complement fixation test, the development of the highly sensitive flocculation tests came year by year. But there were still differences in the laboratories, conflicts of results which made many an honest practitioner skeptical of the wisdom of relying upon the test tubes for a diagnosis which he could not verify clinically.

In bringing order out of this conflict, I am proud of the part which the U. S. Public Health Service has been able to perform. The subject was so broad, forms which could be taken by that master mimic, syphilis, so varied, the usual piecemeal system of case analysis did not readily lend itself to the necessary standardization of practice. Most private practitioners feared to treat syphilis. Many who did *not* fear owed their confidence to the dogmatism with which they clung to the errors revealed in pre-war classes in dermatology.

We had a specific. It was the most satisfactory remedy which had been developed for any disease as serious as syphilis. It was necessary to understand it more thoroughly. It was at that time that I suggested the organization of the Coöperative Clinical Group. A committee of leading syphilologists was formed. They pooled the records of five of America's greatest centers for the clinical study of syphilology, your own University of Michigan, the Mayo Clinic, Johns Hopkins Hospital, Western Reserve University, and the University of Pennsylvania. Here were 75,000 case histories, kept with unusual accuracy. After ten years of work

the records of these cases give us clearer conclusions as to the relative efficacy of various regimens of treatment than had ever been possible before.

Similar disputes in the field of diagnosis gave rise to the Committee for the Evaluation of Serodiagnostic Tests. There were many of these tests, both of the complement fixation and the flocculation type. Under the names of Kolmer, Kline, Hinton, Eagle, and your own Doctor Reuben L. Kahn, these tests were performed by various laboratories.

There are two things necessary to a serologic test. First, the test must be *specific*; that is, when the test shows syphilis, the results should be certain. It should never show syphilis in a non-syphilitic. Second, the test should be *sensitive*. It should reveal syphilis in a high proportion of cases.

Two series of studies were conducted.<sup>†</sup> In the first of these, 1,200 specimens of blood and spinal fluid were collected in sufficient quantity to furnish each of thirteen participating serologists with comparable samples. These tests were made by the serologists who originally described them or by designated serologists in private laboratories. The second study concerned the relative efficiency of State laboratories. These studies of serodiagnostic tests established definitely that it is possible to eliminate entirely false reactions and at the same time to be extremely sensitive.

Other field studies of the Public Health Service showed the epidemic nature of syphilis and the possibility of going back of the case to find the source of infection and contacts. The disease does not spread through the population like a fog over the bottoms. It is kept alive and spreads by a series of epidemics from sources which can be located and brought under treatment. The practical technics of doing this have been worked out.

Prior to the past decade we had no accurate idea of the amount of syphilis being diagnosed and treated in the country. Blood tests on limited groups and inadequate case reports formed no basis even for an estimate. Through painstaking canvasses of state and city we have complete reports of the total patients seeking medical care. Age, sex,

<sup>†</sup>Reports of both these studies and the studies of the Coöperative Clinical Group were published in *Venereal Disease Information*, the publication of the U. S. Public Health Service, and are available to the members of the profession in reprint form.



race and geographical distribution are being clarified.

Just as that point of view was adopted in our approach to these scientific problems of diagnosis and treatment, so it governed our approach to the problem of public health control of syphilis. Nearly three years ago when Congress laid plans for Social Security, it was decided that funds should be available for public health. An insurance program is only as sound as the health of the people who are insured. It was certain that, from the funds set aside for public health, a large amount was needed to aid state and local venereal disease control programs. Among the great preventable drains upon disability and unemployment funds, syphilis and gonorrhea rank high.

In order to develop a national platform of action against syphilis the Public Health Service last winter called together 900 leading syphilologists, health officers and other technical experts to draw the blue prints. The recommendations of this conference represent the group judgment of the best brains of the country as to methods of control.

These studies and policies are described in detail because they form the foundations upon which the current national effort is based and suggest the relationship to the profession that the Public Health Service has taken pains to develop. Aside from our beneficiaries—the merchant seamen, inmates of federal institutions, injured federal workers and some veterans—we do not treat patients. Neither do we assume that our researches constitute an oracle for the profession. It is rather our function to act as a clearing house to stimulate research, to co-ordinate the efforts of divers groups, to serve as a catalytic agent.

As we progress new clinical methods, new laboratory methods, new methods in public health control will be discovered and applied. These methods can be tested by only one yardstick. How effective are they in eliminating syphilis from the community? Does the new method of treatment promise greater hope of cure? Does the new method of diagnosis add precision? Does an innovation in public health bring more syphilitics to treatment and keep them in treatment more nearly through the long course required? Medicine and public health have no functions save to serve such ends as these. We are not dogmatic as to method;

we are tenacious as to objectives and results.

Now, I sum up these three decades and make this prediction upon my belief that they are essential in understanding the problem that faces the physician today. Ford's first car was no farther from the 1937 model than the syphilology of 1900 is from the syphilology of 1937. Consider for a moment, in 1900 the physician relied upon his own unaided resources. There was a physical examination and injections or inunctions with mercury, the dosing with calomel. Today the doctor no longer relies upon his individual judgment. He knows that that accomplished mimic, syphilis, can seldom be safely diagnosed by eye. He is dependent upon laboratory aids. In order to make these aids widely available, a service freely available to all physicians is essential.

In 1900 syphilis was merely the reward of sin. There was no evidence of public interest in the sins of respectable citizens who could pay their bills. If the citizens were not respectable they simply went without treatment until such time as they were eligible for entrance into public hospitals for the dependent insane and disabled. Such was the naive economics of the day. Today, however, a syphilitic is recognized as the focal point of a small epidemic. His contacts are of interest to the health officer. The physician has a responsibility to co-operate with the health authorities to the end that those contacts may be found and brought to treatment.

What happens to those cases when they come to treatment? Some of them are indigent, medically indigent, that is. I would like to emphasize that the same yardstick cannot be used for eligibility to syphilis treatment as is used for eligibility to the relief rolls. A long course of treatment is necessary to render a patient non-infectious or to cure him. That course of treatment is of such length that many patients, who may be able to pay a meager rent or live on a fourth-class diet, will not be able to meet medical bills for such a disease as syphilis, yet it is only through treatment that those patients can be rendered non-infectious and the disease arrested. It is only through treatment that another focal point to a small epidemic can be eliminated. The public interest demands that these cases be treated. There is a medical and a community responsibility from the point of view of mere humanity to see that treatment is



available to these people. It is good community economics to treat them rather than to let their disease develop until disabilities occur. I think it is worth while to point out that it is also first rate medical economics. In order to keep these cases in the hands of physicians wherever possible, free drugs for *every* case is a part of our program.

We are met in some parts of the country with a reluctance on the part of the medical profession to the establishment of public clinics. That matter can and should be settled I think in terms of the sort of criteria which I referred to above. Are more people brought to diagnosis? Are most people kept in treatment longer and more economically?

The physician often loses sight of the fact that for every new patient who comes voluntarily for treatment at least one additional case of syphilis is found when we look for it. Some of these cases come to the clinics. Some of them go to private physicians. It has been estimated that health departments through their follow-up and case-finding activities for syphilis do double the business of private physicians in syphilis treatment. That estimate I base upon reports of clinics and physicians in many parts of the country. There are three principal points which physicians make in pointing out the benefits which have come to them in communities where a well developed program, including well publicized clinic development, is under way:

1. Many more patients come to the physician for treatment.
2. Many more patients who come for treatment are held in treatment over a long period.
3. The physician no longer finds it as embarrassing as he did a few years ago to confront a patient with the fact that he has syphilis.

We have emphasized the public clinic as a part of the state and local venereal disease control program. We have emphasized it because in every country where effective inroads against syphilis have been made that has been a salient factor.

In advising public clinics as a feature of public health organization against syphilis, I do not do so with the idea that some great new state-wide system of clinics shall be set up. Existing hospitals with their out-patient clinics should be relied upon to a maximum degree and aided with public funds. In rural regions where the clinic is not practicable, I

agree with the report of your own society, which emphasizes the subvention of private physicians in rural areas. Yet the first job is in our cities where, in proportion to population, there are four cases for each one in rural areas. Such subvention, of course, should be conditioned upon professional competency and the meeting of certain treatment standards, including treatment over a sufficiently long time to insure noninfectiousness.

Michigan has many advantages over its sister states in the development of its whole public health program. You have a great concentration of industry which offers a real opportunity, through the action of comparatively few industrial organizations, to provide for health education and for healthful working conditions. In providing adequately for industrial hygiene, a great forward step could be taken in advancing the health of your industrial population. Moreover, ill health is bad business.

In the Kellogg and Couzens Foundations, philanthropic funds are available and are at work in the promotion of better health. Your State Health Department and the health departments of a number of your cities have a record of distinguished service. This State Medical Society has long been actively interested in the problems of public health. In the future, even more than in the past, we shall need the synchronized and united effort of all agencies in the state concerned with public health, if we are to make progress in solving the major health problems of today and tomorrow. I should like to see a state-wide plan for public health develop out of the joint deliberations of the several agencies concerned—a plan with definite objectives. In the past we have had in the whole field of public health too much unplanned action. Health progress in the modern community depends upon the mobilization of all resources and all groups directed toward a common end, with clear understanding as to what part each can best play in the composite whole. Above all, health progress requires participation of the whole people. The control of syphilis is a notable example. The same is true in our campaign against tuberculosis, and our efforts to prevent and control mortality from pneumonia. In so far as cancer can be controlled with modern knowledge, progress will depend upon a similar union of effort between the medical profession, the hospi-

tals, the health departments and the citizens themselves. The provision of adequate medical care similarly is of concern, not only to the individual who is sick and to the physician, but to the health department and the whole community which pays whenever its citizens suffer or die because of the lack of medical service. Modern society today lists adequate medical care and health protection as one of the necessities of life.

I am confident that no radical innovations are needed in the work of our profession in order to bring to all citizens the benefits of knowledge which medical science has available. Public health programs and medical practice itself will continue to evolve to meet the changing needs of a changing society. I am much less concerned about the

detailed methods than I am about the objectives. Both the motivation and objectives of public health are seen in their true perspective in an expression by Rosenau, with which I close:

"Preventive medicine dreams of a time when there shall be enough for all, and every man shall bear his share of labor in accordance with his ability, and every man shall possess sufficient for the needs of his body and the demands of health. These things he shall have as a matter of justice and not of charity. Preventive medicine dreams of a time when there shall be no unnecessary suffering and no premature deaths; when the welfare of the people shall be our highest concern; when humanity and mercy shall replace greed and selfishness; and it dreams that all these things will be accomplished through the wisdom of man. Preventive medicine dreams of these things, not with the hope that we, individually, may participate in them, but with the job that we may aid in their coming to those who shall live after us. When young men have vision the dreams of old men come true."

## A CHARGE TO KEEP\*

MAXWELL LICK, M.D.

President, Pennsylvania Medical Society  
ERIE, PENNSYLVANIA



I regard it a signal honor to be invited to address the Medical Society of the State of Michigan. At this time I should like to extend to you, cordial greetings from the Medical Society of the State of Pennsylvania, which I have the privilege of representing.

Health has become a ruling passion. It is a word with which to conjure. Sickness used to be an episode which concerned the patient, the relatives, and the family physician. Now it has the solicitude and surveillance of the economist, the philanthropist, and the politician.

### Increase of Public Interest in Health

The public has become hysterical with repeated journalistic and radio impacts; much of it senseless, worthless, reasonless advice on how to attain health and prevent sickness. Millions of radios daily blare forth the necessity of this and that "vitalized" remedy. Papers and magazines blatantly expound the merits of one medicine after another. Cults with their laying-on of hands and electrical gadgets predict restoration of youthful vigor. Physical culturists with their bulging muscles prophesy charm and renewed vitality. Diet faddists herald a fresh hope to the weary with their unscientific combinations of food. One oracle after another rises up with heteroscopic divinations of that for which Ponce de Leon

sought. Now the economists, the philanthropists, and the politicians have taken up the cry. This insensate, frenzied emphasis on health has confused the lay mind and resulted in much unintelligence because emphasis has been laid on spectacular and unimportant details. It is a psychological law that uncontrolled thought and emphasis may result in obsessions. Perspective may be lost.

### Unemphasized Health Factors

"As Manna fell upon the Israelites in their wanderings through the wilderness, so does good health and sickness, in spite of laws, rules, and regulations, fall inexorably upon the just and unjust alike." Granting the beneficence of preventive medicine, hygiene, and sanitation, the greatest single factor of good health and longevity lies in tissue resistance. It is that ill-defined some-

\*Presented before the annual meeting of the Michigan State Medical Society at Grand Rapids, September, 1937.



thing which was given to us by our progenitors. It is an inescapable fact that many are predestined to diabetes, pneumonia, cancer, mental and cardiorenal diseases. These diseases have varied little, if any, and some of them have increased, and this is the face of scientific medicine. Within this group are the greatest of killing diseases. Their control, management and eradication are certainly not within the province of any form of State Medicine! To affirm that they are is to show a fundamental misunderstanding of the problems involved. It is typical, however, of American civilization to apply modern methods to the solving of medical problems in much the same manner as to business and political problems. This misconception lies in the belief that because we have invented skillful diagnostic apparatus, improved and perfected their therapeutic application, erected imposing hospitals, delved into the function and physiology of hidden and obscure glands, and perfected surgery to a high art—all this need only be applied wholesale and indiscriminately to the public at large, to attain perfection in health for everyone. It is the typical American point of view of interpreting life in terms of size and numbers, rather than in terms of quality and intellect.

It is in these groups that the greatest need lies for improving the race. The understanding of some of these problems lies in the study of heredity and hereditary influences. Their solution will never come from legislators or politicians, but rather by a knowledge of genetics; by proper mating; by adherence to well-known biological laws; by preventing the unfit from propagating; by relieving economic anxiety, by making leisure, calmness and complacency a habit, rather than excitement and confusion. Peace of mind cannot result if the spectre of poverty is ever present. Much of the unhappiness in the world today is due to unrest; to the dissatisfaction of our status in life; to the desire for that which our neighbors have, the acquisition of which only gives us a fresh starting place for something more. It is the siren song of modern life, hurry, hurry, hurry! Just so long as modern living, with its killing competition, with its envy and greed, with its excitement and restlessness, exists, just so long will we have manifestations of nervous and cardiovascular diseases. No amount of health legislation will ever make any difference. The causes

here are economic. Heredity and environment influence to a large extent our health and longevity.

### Prevalence of Superstition and Ignorance

There is still in the minds of the public at large much superstition regarding sickness and its cure. In early days (and not so far back either, for witches were hanged in New England) sickness and pain were regarded as a visitation from an angry God, or possession by an evil spirit. These afflicted people rushed terror-stricken to the priest, the chief, and the medicine man for prayers, sacrifices, incantations, and fetishes, fully believing that if the proper rite were performed, relief would speedily come.

The parallel of this is seen in our abhorrence of the number 13, the carrying of lucky charms, and the bringing of pebbles from Callendar. It has its counterpart in the firm belief that if one only finds the right doctor, he will get the right medicine to effect a cure. It is identical in spirit with those who seek out for treatment the cults who practice the laying-on of hands, and the application and display of mysterious electrical appliances and other doo-dabs. That which is indiscernible and oracular is impressive and implies occult powers. It is, therefore, apparent that we do not have to go back to the dark ages, or to the beginning of medicine to find ignorance and superstition. Crime, unhappiness, cruel suffering, and stark tragedy follow in the wake of ignorance and superstition!

It is human nature to be complacent about health until there is pain or disability. The sick bed usually is occupied before help is sought. Even then, there is widespread confidence in self-treatment, faith cures, divine healing and patent medicines. Irresponsibility, ignorance, superstition, stupidity, lack of foresight and thrift are fundamental human defects, which no amount of legislation will ever correct with any greater degree of success than prohibition stopped drinking.

If these things are true, there is a dire and crying need for better understanding of fundamental conditions. There is a tremendous need for public education. Let fear, ignorance, and superstition be banished so that logical and intelligent methods can be applied to the sick and to the improvement of the race.

By implication and assertion, the medical profession has been placed in a false and



defensive position. It has been made to appear that our services are denied to a large number and that much of our skill and therapeutic agencies are rusting from disuse. We are accused of being a guild, a union, smugly withholding our services except to those who can pay. By habit, custom and tradition our profession has carried on its work without ostentation. Hippocrates bound his students to remain silent by virtue of the intimate character of their work. Because of this established attitude, which I deem essentially right, we have until recently left unchallenged this storm of criticism, implication and innuendo.

The public is told that thousands suffer and die from lack of medical care. I need not tell you, my friends, that the state of health in this country is on a higher plane than at any other time in its history. I need not point out that sickness and death are immeasurably less here than in other countries of comparable size. I need not affirm that our efforts in preventive medicine have resulted in the control and almost the eradication of certain diseases, so that statisticians tell us they will eventually be found only on the pages of history. I need not inform you that the medical profession has performed its duty to the needy, completely, without reservation or complaint, during the unprecedented years of the depression.

I need not authenticate that many people—a large number—never do need any medical attention. Of course, many have chronic defects. Many of you in this audience have chronic ailments of a minor degree which in no way materially affect your general health. The correction of these is entirely a matter of your own volition. If doctors' offices dotted the landscape like the ubiquitous billboards and gasoline stations and the services were all free, the public still would not seek attention for chronic defects.

I need not attest that medical service can be had by any who have interest, volition, and intelligence enough to seek it. I need not establish that coercion by law is contrary to human nature. Irregular practitioners will find favor with multitudes in preference to doctors as long as ignorance and superstition dwell in the human mind, leaving in their wake tragedy, suffering, incurable diseases, disappointments and frustrated hopes, while the coffers of those who lawfully exploit human suffering and credulity bulge with their ill-gotten gains. What a

paradox it is that doctors of medicine must by law conform to exacting and meticulous standards, while the others, without knowledge, without cultural or scientific training, may practice the healing art, with their unscientific and even more ridiculous methods! The laws of our glorious republic safeguard this wonderful body of ours from the ministrations of the doctor, but hand it over with confidence, childlike simplicity and innocence, to the depredations of any one who calls himself a healer. By any stretch of the imagination is there any reason or logic in such solicitude on the one hand, and such utter indifference and unrestraint on the other? It will be a blessed day for the public when all who practice the healing art, no matter by what method, are compelled to submit to the same training and conform to the same standards. It should make no difference whether drugs are used, diets offered, or surgery practiced. Ignorance, delay and improper practices have transformed many curable cases into hopeless invalidism. Legalized murder certainly exists elsewhere than within prison walls and on the fields of glory!

I emphasize all this because health insurance takes no cognizance of these evils and their pernicious effects. The public, because of general unintelligence and susceptibility to advertising, believes implicitly in a specific cure for all ailments. The patient regards his "indigestion" as a distinct entity, separate from relationship to the rest of his body. With all the impacts concerning health which he receives, there is no cause for astonishment when he seeks a remedy from some prophet or evangel who promises to cure him. The doctor knows that the body and its ills must be considered as a whole, and not that alone, but must be envisioned for complete understanding in relationship to its environment and heredity. Ambitions, hopes, disappointments, envy, greed, jealousy, suppression—all these color the canvas, portraying the picture of personality. They are currents which may lead this frail craft, not only to peaceful, placid waters of complacency and stability of mind and body, but also may dash it on the jagged rocks of mental and physical disaster. Is there any likelihood that these evils will be corrected by any pattern of medical reform? Do we not need more education and less legislation?



### Influence on Medicine of Changing Political and Economic Concepts

In order to understand this agitation to make over the medical profession, one has only to take cognizance of the radical trends of thought throughout the entire world. Has the world been made "safe for democracy?" Is it indeed not quite the opposite? We have seen democracy demolished and in its place have come Fascism, Communism and Nazism. Political and governmental conduct has been radically changed. There has been a tendency, the world over, of the State to ascendancy, with the result that the effort of the individual has been less effectual and less fruitful.

It has been affirmed, by those more eloquent than the speaker, that this country was formed and developed by our forbears who fled Europe to escape the omnipotence of the King and the evils of an autocratic group, that they might enjoy freedom of thought, speech and action. All history proves that the greatest of civilization and cultures were those developed where the individual was paramount. Greece reached its greatest heights in the time of Pericles, Plato, Socrates, and Aristotle. The Renaissance in Italy and England was the result of an exuberance of individual expression. France began its greatest glory when the Bastille was stormed and the heads of the civil and dominating group fell into the bloody basquets. Freedom of religious thought and belief was only attained when the people rose up and purged the nations. The thorny path led Copernicus to banishment; Servetus and Savonarola to the burning stake, and many other individuals to the dagger and the rack because they raised their voices in protest against the dominance of an unfair and unjust group.

You say these are unfair parallels. You say such things cannot happen here. They have happened in this twentieth century in Europe. Great scientists have been banished and made fugitives. Illustrious physicians have been denied the right to practice. Scientific knowledge of great value has been refused publication while other scientific books have been destroyed. Liberty, freedom of speech, thought, and action have undergone decay in many Continental countries. The State is all-supreme! Conscience is dulled and suppressed!

Our own country has not escaped the influence of these currents of thought. We see

increasing governmental interest in civil and industrial activities. These new concepts have created a doubt in the worth of our traditional sanctions and have shaken the confidence in our established institutions. Is not the attack and the diligent program of discrediting the medical profession only an example of the powerful economical forces exhibited in all human activities? Has not the unrest and the uncertainty of economic forces filtered and permeated all phases of human endeavor? One heard little of Socialized Medicine until the depression devastated the business and morale of our citizens. Now it would appear as though most of the ills of humanity could be laid at the door of the medical fraternity. There were no grounds for complaint until this economic confusion occurred. It is inevitable, in times of crisis and despair, for self-appointed evangelists, imbued with a sudden burning and consuming humanitarian thirst, to rise up and lead the discouraged, who with outstretched arms, stumbling feet and eager faces, follow with childlike trust as did the children after the Pied Piper, only to find disillusionment and frustrated hopes. The magic prescription of these modern soothsayers and social astrologers seems strangely reminiscent of the "shot-gun" mixtures of our own twilight medicine!

Tragedy and economic crises result in a dislocation of logic and of our established concepts. We lose sight of fundamentals and grasp at plans and panaceas, especially if they are prophetic and sanctimonious. Human nature has ever been thus. The facts of life are often stark and cruel. It is human nature to seek comfort, solace and relief from actualities. Therein lies the lure of drugs and alcohol with their comforting and exalting effects. In like manner we eagerly seek "the promised land" of social and economic problems, soothed into intellectual anesthesia and expansive well-being by the breath-taking beauty of the vision. The best social insurance that I know of is work. Work that pays a good wage. Work that stimulates incentive, encouraging thrift and frugality. Work that rewards the worker in proportion to his honest effort. Work that provides independence and liberty and opportunity to purchase medical service, when it is needed and from whom it is desired. I challenge the statement that we need to change some of our institutions! Honesty, thrift, integrity and sanity of out-

look are still fundamental. Patronage and dependence are likely to undermine the character and breed laziness, insolence and revolution. Economic crisis, ravages of flood, famine and drought have existed since the beginning of time. They are inexorable and inevitable. The silent machinerv, the smokeless chimneys, the red entries in the ledger, poverty and tragedy, are stark symbols of man's impotence against natural and economic forces. Can it be denied, then, that this attack on medicine is a symptom of the times? Is it not analogous to the treatment of a cough when the patient has pneumonia? Do we not have the cart before the horse? In our bewilderment we often seek the easiest explanation of truth. "One may dive too deep or soar too high and the truth escapes." The medical profession has no cure for the ills of the body that are dependent upon the ills of society. Should we not hold steadfast to those established institutions which have stood the test, regardless of failing confidence and economic confusion? Should we not cling unwaveringly to individualism in medicine until the wheel turns again when sanity, work and thrift will be fundamental?

### The Art of Medicine

The practice of medicine is largely an art. Music, poetry, painting, and sculpture were highly developed and indeed had attained perfection when medicine was still in its crude beginning. Nike of Samothrace (Winged Victory), Venus de Milo, and the Laocoön, sculpture that has never been excelled, were produced a century or two B.C. Homer had written his *Odyssey* at a time when diseases were treated by superstitious rites, or by the giving of horrid concoctions. Chaucer had written *Canterbury Tales*, two centuries before the ligature was applied to an artery to control hemorrhage. Rembrandt had painted his great picture, The Anatomy Lesson, two hundred years before Pasteur linked bacteria with disease, and Michelangelo was spreading his canvases with infinite beauty, long before this.

But, I call your attention to the fact, that although the science of medicine was little, if at all understood, in those early days, the art of the physician was bringing sympathy, cheer, and restoration to health. Those glorious words of Hippocrates, transcending most human attributes illustrate the constant guiding principle. I love to contem-

plate them, "I will follow that method of treatment, which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. With purity and with holiness I will pass my life and practice my art. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption. While I continue to keep this oath unviolated, may it be granted to me to enjoy life and practice of the art, respected by all men at all times, but, should I trespass and violate this oath, may the reverse be my lot."

No more inspired lines were ever written! No more blessed rules of conduct were ever promulgated. And, so down through the centuries, these principles have been paramount in the practice of medicine. It recognizes that often the greatest good that we bring to our patients, lies outside the giving of drugs.

Formerly, the doctor was the family counselor in many problems aside from that of illness. No one, not even the spiritual advisor, knew the troubles that beset the family circle, better than he. No one came closer to the inner life of the family. It was he who inspired that confidence and trust which stimulated the will to believe and to get well. It was he whose counsel was sought when trouble, trial and tribulation laid their heavy hands upon the family life. It was he who was first thought of because of his intimate knowledge of all that concerned the family from sickness to domestic or economic difficulties. In him was placed that reliance, trust and confidence that brought, in most instances, peace, tranquility, and adjustment to those within the family circle. The Man of Galilee himself was called the great physician not only for his ability to heal the sick, but also for his ascendent powers to sympathize, to encourage, to strengthen, and to make the rough places plane.

The practice of medicine, however, is not the simple thing that it was in those days. There has been a tendency to regard specific diseases as separate entities. This probably has resulted in over-specialization. For complete understanding one must think of the entire organism as a personality. We, as a profession, are likely to fall into the same trap as those economists who would make medicine a business-like science. Their



theory is predicated upon the assumption that sickness and disease can be classified in the same manner as botony specimens, and all that is necessary is to apply the cure. This is far from the truth in many instances. It is the personality, the ego, that is frequently out of adjustment with its environment. Stress and strain of economic existence and the pull of hereditary factors are at the bottom of many illnesses. This has been especially true since the depression came. Our profession has given too little thought to those ills, with the result that psychologists and psycho-analysts have supplied the need to these suffering individuals. These personalities need sympathy and friendly counsel, as does the parched field need the gentle rain. Let us give more thought and attention to the sick personality! Let there be a return to the family doctor and less specialization!

Those who talk so glibly of making over this profession of ours—this profession, rich in traditions; this profession which has attained such noble worth; this profession surfeited by kindness and sympathy; this profession whose only pass-words are mercy and pity—lose sight of the art of medicine. They would reduce all these human attributes of kindness, pity and mercy, to a formula. They would put the matter on a business basis, under the assumption that only scientific medicine need be applied to the sick in order to affect a cure. What an abysmal misunderstanding of the principles involved! What gross injustice and what cruel denial would result, to many, many personalities! The art of medicine and its application must remain unchanged. Nothing must make unheard those words so often expressed by the sick, "Doctor, I'm so glad you have come." There is wrapped up in that one sentence the epitome of the medical art which has existed through the centuries. It is akin to the child who reaches out his hands to his mother and finds solace and understanding in her arms.

The art of medicine has not changed. The pass-words of mercy and pity, are the same today as in the days of Hippocrates and the Doctor of the Old School. These qualities of the human soul must not die if the art is to exist. Would you have me believe that they can be taken over by the politicians, and bureaucrats? Would you have me think that they can be reduced to a business formula? Would you have me think that they

can be turned on and off by a switch? I call you to witness, that this can no more be done without debasing the quality, than one can stifle the love in the human breast for its creator, without dwarfing the soul.

### Medicine an Altruistic Art

It was Alexander Poe who said, "Be not the first to try the new, nor yet the last to lay the old aside." We all resent changes of existing conditions. The speckled bird represents the psychological principle in our objections. That which is new or unusual, excites resentment. There should be no need of saying that the medical profession, above all others, would be the first to adopt any change which would result beneficially to the public health. If this is not true, then indeed, have our traditions, our altruism, our purpose, our ethics, been a living fraud. Is it not our duty by virtue of our training and knowledge of medical problems, to protect the public from the adoption of suddenly conceived, overnight schemes which would result in the deterioration and prostitution of the medical art? Can our motives be impugned; can we justly be called selfish when we strive to maintain the finest quality of medical service in the world? Can we be reproached; can we be convicted of deceit when we oppose the control of medicine by politicians with all the inevitable and shameful patronage and waste, in which political machinations result?

We have been called ungenerous, mercenary, illiberal, and selfish. If to teach principles of sanitation and hygiene, if to broadcast rules and programs of maintaining health, if to give freely the discoveries of science resulting in the eradication of suffering and disease, if refusal to patent new remedies, or to keep them hidden and secret, if to maintain clinics and hospital wards without recompense, if to apply knowledge of preventive medicine to the wiping out of specific diseases, if constantly to diminish our private practice and business by the dissemination of all this knowledge—if all this be ungenerous, then Thank God, I belong to such a selfish group!

We believe as a profession that whatever is just and right for the individual is just and right for the group. It is our habit and custom to render services to the individual at reduced fees, when circumstances deem it to be fair and right. If this principle is equitable, then it should be applied under

similar needs and conditions, to the group. To this end, and with the approval of our parent organizations, certain plans of voluntary hospital insurance are being tried. This seems to me to be just and proper for out of it may evolve a workable, suitable plan, free from political or other extraneous influences which will meet the major expense of hospital confining sickness for those least able to afford it. One lacks the wisdom of a sage or the temerity of the foolish to outline a definite plan of that which is still experimental.

We certainly affirm our desire of instituting any change made necessary in view of different economic conditions. We want those innovations, however, to come gradually, to be built up solidly by trial and error. Science grows thus. An observation, a fact, a theorem, finally a proof. So with us. Let changes come by attrition. Let there be no radical stampede resulting in disappointment, retrogression and frustrated hopes. This is my answer to those of our profession who clamor and cry for a definite, militant program of our own. It would take divine wisdom to forsee the future, but it only requires common sense to keep constantly before ourselves, before the public, and before our legislators, the necessity of maintaining unsullied, whatever is noble and worthy to the medical art! The only guide we have for the future is experience. Experience is largely the record of our mistakes. Lord Byron said, "The best prophet of the future is the past." There is ample evidence in events of the past of the deterioration of medicine under political influence. There has been no particular dissatisfaction of the public with the present type of medical service.

### Social Insurance Not the Answer

I have considerable faith in the intelligence and motives of our legislators. I cannot believe that they, with a complete knowledge of such experience, would countenance any such system. I ask them, and the American people if social and health insurance has strengthened and fortified governments; has it lessened poverty; has it added to individual happiness and security; has it lessened sickness and morbidity; has it lengthened life; has it done any of these things in those European countries where it is practiced? Let us not substitute rhetoric and emotion for logic. The answer is "NO!"

There is a greater public consciousness than ever, that we are indeed "our brothers' keeper." But, let us see to it that he has an opportunity of keeping himself. He should have the opportunity and the right to remain independent and not become a "poor relation." If socialism is just and needed, then let us socialize everything. But, if we still believe in the principles of democracy, guaranteeing liberty in thought, speech and action, on which this country was founded, let us adhere to them with perseverance, moderation and firmness. We want none of those European systems. We do not want American medicine inoculated with the festering sores of political control; with malingering patients seeking cash benefits; with clerk-like prescription writing doctors, exhibiting lack of personal interest. These are veritable cancers, insidiously impairing the worth and prostituting the art of medicine. We do not want a legislation which benefits one class at the expense of another. Health insurance does not profit the clerk, the farmer, the self-employed, the domestic, or the indigent. Health insurance takes no notice of the manufacturer, the executive, he whose efforts and ability gives work to thousands in this country. Verily, these are blessed and forgotten souls. It would indeed be revolutionary if some one thought of protecting them when adversity struck. We do not want a tax on the already pitifully thin pay envelope of the worker; on burdened industry; and on the heavily taxed citizens of the State—a tax that is uneven in its assessment and uneven and unfair in its benefits.

We are indeed a profession set apart. We must not lose the conviction that we are dedicated to the care of the sick. Down through the ages this has been our duty. Unless we cherish a cordial habitual and immovable attachment to this heritage, something of value will be irrevocably lost. The members of the Medical Society of the State of Michigan, with their culture and knowledge, represent an invincible force for good. I beg of you, for the public good, that you remain unified in motive and purpose, filled with enthusiasm and imbued with the justness of your cause.

### A Charge to Keep

Ah, my confreres, we have a duty to the public and to ourselves. We have a charge to keep! A charge from those whose heritage we prize; those who now sleep the long



sleep; those whose minds and hearts must have been akin to the Divine because of their noble motives and purposes; those whose work has shaped and directed currents of civilization and made the lot of mankind better than any statesman, warrior, or general; those who gave us the tradition of beneficent service to all who

suffer; those whose love of humanity surpassed even that of the love of woman; those whose paths led to a martyr's grave that science might advance. Their spirit is not dead! Their precept and principles, examples and teachings, will live not only on the pages of history, but in the hearts and minds of all worthy to be called physicians.

## NEUROPATHOLOGY AS A SCIENCE\*

### Report of the First Hundred Neuropathological Specimens in Detroit

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In a recently published book† a neuropathological study is based upon a survey of lesions found in a series of fifteen thousand autopsies performed in the Los Angeles County Hospital. The faith one has in high figures is often too implicit notwithstanding the modern trend of accumulation of mass data. This paper is relatively a study of value only so far as there can be presented reasonably accurate and precise records collected and studied almost coincidentally with the time immediately following the autopsy work. And further, all of the brain autopsies were done personally. There may be some value in presenting the first hundred cases and a promise of additional hundreds to follow as soon as available, thereby keeping close to the problems while records are new. Certain difficulties in recording precisely the observations of a large group of cases will be discussed.

In *neuropathology* the usual routine examination requires a great deal of time, experience, accuracy, and technical assistance. Most of the different organs and structures within the cranial cavity cannot be satisfactorily investigated by the same pathological procedure which is used for examining other organs. Therefore, it is not surprising that neuropathology as a science was developed, not by pathologists, but by neuropsychiatrists (Nissl, Alzheimer, and others). Significant pathological features of many brain diseases could be disclosed by neuropsychiatrists. It is no wonder that the development of neuropathology was dependent upon the progress of neurology and psychiatry. More recently a great step forward was made in the pathology of brain tumors. This was due mostly to the work of neurosurgeons (Cushing and others). At any rate, the evolutionary process of neu-

ropathology was rather independent from pathology. The reasons may be as follows:

1. The central nervous system is composed of some structural elements which are not seen in any other organs of the body.

2. Some of these structures can be shown only by particular staining methods. For routine and research work in neuropathology specially trained technicians are required.

3. Some of the tissue elements of the central nervous system, especially the nerve cells, have to be considered as the highest grade of cellular differentiation compared with other cells of the body. The nerve cells are very susceptible to even the slightest injuries. Therefore, these nerve cells, together with the other parenchymatous (axis cylinders, myelin sheaths) and glial structures, vary greatly even under normal circumstances. Here there are frequent and different agonal and early postmortem changes. Thus it may often be very difficult to distinguish between accidental and essential structural deviations. This requires a long experienced knowledge of the normal, agonal and essentially pathological appearances of the tissues of the central nervous system.

4. In the liver, the lung, the spleen, and in other organs, all parenchymatous areas

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†Cyril B. Courville, M.D., "Pathology of the Central Nervous System," Pacific Press Publishing Assoc., Mountain View, California, 1937.

are more nearly anatomically and physiologically equivalent. The function of these organs depends entirely upon the quantity of the diseased parts. In the brain and spinal cord the various parts differ greatly in their structures as well as in their functions. The brain cortex shows different units of nerve cell layers, the so-called cytoarchitectonics. The caudate nucleus, the putamen, the globus pallidus, the optic thalamus, the substantia nigra, the cerebellar cortex, the dentate nucleus of the cerebellum, the inferior olive, to mention only a few of these circumscribed nerve cell accumulations, are of quite different size and shape. It is justifiable to state that most of these nerve cell units are also of a peculiar function. Moreover, the same etiological agent may produce different pathological pictures in the various cell units of the same brain. On the other hand, a very similar pathological picture may have different causes. To complicate the situation still more, there are very many connections of nerve cell units by nerve fibre bundles and tracts. By these a damage of a definite nerve cell unit affects another occasionally far remote unit of the central nervous system. Therefore, the primary or secondary character of a lesion has to be recognized. Thus, for a satisfactory pathological examination of brain lesions a minute knowledge of the units and their connections is necessary.

5. Many brain diseases do not show any gross focal or diffuse lesions (encephalitis group, Alzheimer's disease, early stages of general paresis and Wilson's disease). Therefore they cannot be recognized by the naked eye, and microscopic examinations become necessary. Microscopical lesions, occasionally very small, are sometimes confined to particular regions of the brain or spinal cord. The routine technic of using four to eight or even twenty small paraffin tissue blocks for microscopical examination would be inadequate for detecting small lesions. In some instances large sections may be useful for this purpose. By using the Christeller table for frozen blocks large sections can be made and a large amount of brain tissue can be examined in a comparatively short time. But this can be done only by a special technic. In order to find macroscopically unrecognizable lesions one may refer to the clinical symptoms. Our clinical

experience leads to the point that distinct neurological or psychiatric symptoms often run parallel with changes of particular nerve cell units. Therefore, the neuropathologist has to be trained in neuropsychiatry also.

6. The kidneys, the adrenals, and many other organs show a bilaterally symmetrical arrangement. So does the brain. When one of these bilateral organs is removed, the remaining one will probably show some compensatory hyperplasia. We do not know enough of this very interesting problem, but it is quite certain that by the removal of one entire brain hemisphere or of a large part of it, no hyperplastic or hypertrophic compensation will be produced in the remaining hemisphere.

Moreover, both cerebral hemispheres are not of equal functional value. The location of speech centers in the left brain hemisphere of the right-handed man and the reverse location in left-handedness indicates a somewhat superior function of one hemisphere over that of the other.

Mute cortical areas are so-called because of functional deficiency. I would prefer to say, they are supposed to be mute because, at the present time, we are unable to understand the language of their functions.

All of these problems, and others of insufficiently explained brain functions, increase the difficulty of neuropathological examinations.

Now it may be understood that neuropathology requires special study and knowledge. It would be impossible, even for a well-trained pathologist, to fulfill all of these requirements of neuropathology. In a few hospitals for nervous and mental diseases, neurological institutes, state hospitals, medical colleges, there are already neuropathological laboratories, and there will be more of these laboratories in the future. This will be an important step forward in the combat with organic diseases of the central nervous system.

In organizing a neuropathological service<sup>‡</sup> in Detroit, commendable support was given by the departments of pathology of two large hospitals in which many patients with nervous and mental diseases have been

<sup>‡</sup>I am indebted to Doctors J. E. Davis and A. L. Amolsch, to Doctors O. A. Brines, D. C. Beaver, D. G. Christopoulos, S. E. Gould, and Frederic Schreiber, for placing at my disposal valuable material.



treated. In these hospitals there are also departments of clinical medicine and surgery. The brain and occasionally the spinal cord were removed at autopsy in the usual manner and preserved in formalin. The brain was preserved in every available case with manifest neurological or psychiatric symptoms, in every case of unconsciousness, and in many other cases of unexplainable death or in any case in which a brain involvement was suspected. Every brain autopsy was done by the author. So this material consists of somewhat collected but equally examined cases. Among the one hundred cases fourteen brains were found in which neither grossly nor microscopically any abnormal change was seen (cases of pneumonia, kidney and liver diseases, heart failures, and so forth.) In eleven tumor cases no metastasis to the central nervous system was present. In the remaining seventy-five diseases there were encountered thirty-seven cases of cerebral arteriosclerosis, eleven brain tumors (including five metastases) six meningitides, five cases of neurosyphilis, five cases of worm-like state (*état vermoulu*), three recent traumatic lesions of the brain, two cases of dementia senilis, two cases of peculiar and to date unobserved intraventricular adhesions, one case of acute and chronic alcoholism with hemorrhage, one Wilson's disease, one myotonic muscular dystrophy, and two different endocrine diseases. Here there are seventy-six enumerations because one meningitis case was combined with a worm-like state.

The most outstanding fact in our statistics is the frequent incidence of *arteriosclerotic cerebral changes*. Out of the thirty-seven cases of cerebral arteriosclerosis only eighteen showed severe damage to the brain substance itself, which could be seen grossly. In nineteen cases arteriosclerotic vessels were present without any gross appearance of malnutrition of the parenchymatous tissues. Occasionally it occurred even in rather severe arteriosclerotic changes of cerebral arteries.

At the present time it is not known why severe damage of the tissues is seen in some cases and not in others, in spite of the same arteriosclerotic appearance of the cerebral arteries. Arteriolosclerosis was very often combined with arteriosclerosis in

the same case, but it cannot be said that in old age cases the combination was more common than in younger individuals. In one patient, aged 32 years, with malignant hypertension only arteriosclerosis was found. This case is not included among the thirty-seven arteriosclerotic cases. The eighteen cases of cerebral arteriosclerosis with parenchymatous damages were arranged as follows: Two cases with only one focal lesion; thirteen cases with more than one focal lesion, usually three or four or even more; three lacunar states which must also be considered as multifocal lesions.

Two more lacunar states were found which were combined with arteriosclerotic softenings.

Recent arteriosclerotic hemorrhages were found six times, among which a rupture into the lateral ventricle was seen twice. The ages of the arteriosclerotic patients ranged from forty-nine to eighty-eight years. It was very surprising that among younger individuals the multiplicity of arteriosclerotic lesions was more frequent than in older cases. The lacunar state was found in four old age patients out of five (four over seventy years of age and one aged fifty-one years).

*Primary brain tumors* were seen in five cases: three glioblastoma multiforme, two in the right frontal lobe, one in the left temporal lobe; and two meningiomas.

*Metastatic tumors* were seen in five cases, among them three bronchiogenic carcinomas, thirty-nine, forty-two and forty-eight years of age. In the first case a large number of circumscribed tumor masses of different sizes, from that of a pea or cherry to that of a small tangerine, were found. The left cerebral hemisphere contained eleven neoplasms, the right seven. There were four in the cerebellum and pons. The total number was twenty-two. The small tumor nodules were rather firm and solid. The larger ones showed cavitation, cyst formation and necrosis. One tumor mass had ruptured into the lateral ventricle, and it was very interesting to note that far remote from this region the bordering ependymal cells were covered by an accumulation of typical tumor cells. This was seen only once.

In the second case of bronchiogenic car-

cinoma two tumor masses were found, one in the right corona radiata, the other, a smaller one, in the right occipital lobe.

The third case showed only one brain metastasis in the left frontal lobe.

In two other cases of metastatic brain tumor the primary tumor was in the breast. In one of these cases two metastases were found, one in the left pulvinar near the midline, and the second in the cerebellum. In this case the cavity of the septum pellucidum was extremely enlarged. The other case showed only one metastasis in the right frontal lobe.

In eleven *carcinomatous cases without metastasis* to the brain the primary seat was the stomach in four instances, twice in the cavity of the mouth, and once each in the rectum, in the head of the pancreas, in the prostate and in the skin.

It must be emphasized that *traumatic lesions* were very frequent, for most traumatic conditions in which death occurs are examined by coroners and are not available for our statistics. Old traumatic injuries of the brain were accessory findings in our brain autopsies in five cases, four of which were males and one a female. As far as could be elicited the accidents occurred a long time before death. Therefore this traumatic condition was found in older subjects—fifty-five, fifty-nine, sixty, sixty-three, and sixty-five years of age. In all cases one or both orbital parts of the frontal lobes were involved. In three cases the temporal lobe with the pole and anterior parts of the first and middle temporal convolutions were damaged, twice on the same side as the orbital lesions, once in the right orbital and left temporal convolutions. One case was combined with a meningitis caused by *Bacillus mucosus capsulatus*. The characteristic appearance of these superficial cortical lesions with their brownish discoloration is known as worm-like state (*état vermoulu*). By some writers the traumatic worm-like state is distinguished from the arteriosclerotic, and it is claimed that the scar formation in the former is on the top of the convolutions and does not reach each of the walls, but in arteriosclerotic cases it should be the reverse. In this series of 100 cases such was not the rule.

Three *acute traumatic conditions* were seen, the first combined with a skull frac-

ture and a large subdural hematoma over the convex part of the right hemisphere with depression of the brain substance. Large hemorrhages in the subarachnoid were noted in this case, and cortical hemorrhages were seen on the orbital parts of both frontal lobes and the poles of both temporal lobes. Here there was a severe destruction of brain substance. In the second case a subdural hematoma was found. The third case showed a rare picture. A twenty-three year old man had fallen down about four stories in an elevator shaft. Both tibiae were broken by compound fractures. The skull was not injured. The patient did not lose consciousness until thirty-six hours later. He died without regaining consciousness four and one-half days after the accident. At autopsy very numerous petechial hemorrhages were seen only in the white matter of the hemispheres. Even the basal ganglia were not involved but in the internal capsule between the nucleus caudatus and putamen multiple small bleedings were present. The size and shape of these pinpoint-like bleedings varied, but they were all less than a millimeter in diameter. The shape of the bleedings was round or oval and only a few appeared cylindrically shaped. The distribution of the bleedings differed throughout the various parts of the brain hemispheres. In both *frontal lobes* the petechiae were scattered throughout the *entire* white matter. Farther posteriorly, just behind the openings of the lateral ventricles, the bleedings were confined mostly to the dorsal parts of the white matter, forming a definite transverse line between the upper parts of the brain hemispheres, with very numerous pinpoint-like petechiae, and the parts below. In these areas only a small number of bleedings in the temporal convolutions were present.

In the cerebellum the white matter showed the same aspect of pinpoint bleedings, whereas in the gray matter only a few were present. But in the white matter of the cerebellum the petechiae were less frequent than in the white matter of the cerebral hemispheres.

The microscopical examination revealed the typical picture of petechial bleedings with ring-like arrangements. It would be incorrect to speak of hemorrhages because the vessel walls were not ruptured. The bleedings must have been caused by diapede-



desis. The bleedings did not join together. By cutting the same tissue block first perpendicularly to the surface of the cortex and then tangentially the aspect of these petechial or ring-like arrangements did not change. The fat stain showed capillaries filled with continuous fat cylinders without droplet-formation. But this picture was confined to the gray matter and was absent in the white. By the phenomenon of fat embolism it cannot be sufficiently explained that the bleedings were confined to the white matter in which fat-studded capillaries were absent. Moreover, the above-mentioned picture of a rather sharply limited zone of dorsal and upper parts of the hemispherical white matter scattered throughout with bleedings, and an inferior or ventral zone without bleedings or with a few, could not be explained by fat embolism.

The six cases of *meningitis* were as follows: Four cases were caused by the pneumococcus and occurred among three adults and one infant six months of age; all of the subjects were males. One male case of meningitis caused by Friedländer's bacillus was combined with a worm-like state. The last case, a female, was one of an early tuberculosis. In this instance the choroid plexus showed a very large inflammation and some round spots of necrosis.

Among five cases of *neuro-syphilis* were included three cases of general paresis, one case of chronic lymphocytic meningitis, and one case, a patient, forty-two years old, with endarteritis obliterans followed by thrombosis and hemorrhage. Two of the parietic cases were caused by acquired syphilis, and one case was due to congenital syphilis in a patient with juvenile paresis at twenty-seven years of age. The histological pictures of general paresis were completely changed when compared with the classical descriptions of Nissl and Alzheimer insofar as the cortical inflammatory signs were not seen in the anterior parts of the brain or only to a small and circumscribed extent. Circumscribed cortical demyelinations seem to be frequent in these cases. The patient with endarteritis obliterans showed small

circumscribed subarachnoidal hemorrhages involving the frontal base, both frontal poles and the area of the sylvian fissures of both sides. The largest hemorrhage was seen in the interpeduncular cistern covering the optic nerve, chiasm and oculomotor nerves, the vessels and the corpora mamillaria. The left mamillar body was infiltrated with blood and in the surrounding white matter above this nucleus some hemorrhagic spots were present. A small blood clot could be seen in the third ventricle, and surrounding this cavity, in the subependymal regions, lymphocytic infiltrations of the adventitial walls were present. The pia was infiltrated with lymphocytes and plasma cells.

A rare finding was observed in the brain of a sixty-six year old woman: A microscopically diagnosed Alzheimer's disease was combined with brain swelling. The brain weighed 1,660 grams and the convolutions were flattened. The body was emaciated. This brain swelling concealed any signs of brain atrophy.

In a case of *chronic and acute alcoholism* of a patient aged thirty-two years, numerous hemorrhages were seen in the brain substance itself, involving the peduncles as well as the pons. The aqueduct was filled with clotted blood. A small amount of blood clot was present in the fourth ventricle.

This statistical study regarding brain involvement in disease resolves itself into a long list of research questions and problems.

The *science* of the normal brain, the neuroanatomy, is already well developed in this country. But our knowledge of the diseased brain and its pathological changes, *i.e.*, the *neuropathology*, is in its first ataxic steps of childhood.

The use of the word "brain" by laymen is very popular, as proved by such expressions as "brain child," "brain trust," and others. May the extensive use of this word and the knowledge of the importance of this organ lead to an intensive support of neuropathology. In Detroit a wealth of material is available for study and research.

## THE MENTAL HYGIENE CLINIC AND THE SCHOOL

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The progress of our civilization during the present century has produced seemingly permanent modifications in family life and these changes have altered the relationships between parents and their children. There are those among the sociologists who believe that the disintegration of the family has already taken place. The school has reacted to these changes within the family by taking over many of the functions of the home. As recently as ten years ago, mental hygiene focussed its attention principally upon the child in the pre-school era, while today it concerns itself equally with what happens in the kindergarten and elementary school. The educational experience has come to have greater significance in the lives of children and teachers now exert an increasingly important influence in shaping the ultimate destinies of pre-adolescents.

It is, therefore, pertinent to discuss that which has heretofore been regarded by the educational system as of secondary importance. I refer to the unintentional performances of teachers and the profound effects of these unrecognized attitudes and prejudices upon the subsequent lives of the children entrusted to their care. The discussion of this problem is of vast importance in order that we may appraise ourselves of the possibilities for increasing human opportunity and preventing the widespread development of disordered personalities. A school is only as great as its teachers and if I devote myself mainly to pointing out the deleterious effects unwittingly produced by educators, I trust you will understand that I do so for a constructive purpose. It is much easier to study our successes than to investigate our failures. It is my purpose to acquaint you with certain facts and conclusions to which my attention has been drawn through contacts with the inner lives of many children whom I came to know through my work in child guidance clinics. These facts and conclusions I will undertake to lay before you in the light of psychoanalysis, the source of our most valuable knowledge of the development and function of the human mind.

Before considering the relationships of teachers with their pupils and how this affects the learning process and the character of the child, it is necessary that we possess a correct orientation about human personality and a clear conception of adequate goals in education. In a broad general sense, much of what I have to say has always

been known but its importance has been neglected and this comes about through the fact that our culture has flourished through the growth of information about everything but people. Yet, civilization is in last analysis a performance of people and the GREAT civilization must not only utilize the natural resources of the physical and biological universe but must also economize and conserve the resources of the psycho-biological universe—that is—man. I am reminded in this connection of the thesis of one of my colleagues to the effect that there is no more urgent problem before us than the exploration and assaying of technics in inter-personal relationships.

Personality grows from the equipment with which we come into the world through the experience that life gives us. It is rather conventional to assume that we are to a great extent masters of our fate. This notion has to be abandoned as soon as one discovers how final and all but irremediable are the effects of experiences undergone in the first fifteen years of life. Consider, for example, the prevalence of delinquency and crime in our society and witness the crowding of our reformatories and prisons. The finest minds in the world have devoted themselves assiduously to the reclamation of this human wreckage and yet in only a small percentage of cases have they succeeded in changing these anti-social characters. These criminal careers had their beginnings in the earliest years and by the time they attained late adolescence, they were within the grips of internal forces over which they had no control in spite of their well-meaning resolutions and good intentions.

Man readily accepts the fact that there are many activities of his physical organization over which he can exercise no mastery.



He knows that such physiological functions as circulation, digestion, and the ceaseless workings of the glands of internal secretion are beyond his awareness or his influence. On the other hand, he protests violently when he is informed that his conduct is not a witting performance based on intelligence and choice but is instead the outcome for the most part of unconscious processes of which he knows nothing. In the choosing of one's life work, conscious motives are partly directed by unconscious impulses which find expression in the profession or occupation which the individual selects. These internal drives are principally instinctual and may be described as having belonged to the earlier life of the individual. Although long since cut off from awareness—that is, repressed—they continue to retain their dynamic force and to influence to an appreciable degree the decisions which persons make. This knowledge of the dynamics of human personality founded upon thorough scientific investigation has been met with fierce opposition by even the most intelligent. This is not an unusual reaction. With all his seeking out of new things, man has always displayed hostility to the acceptance of new ideas. If we reflect on the well-known historical examples of this conservatism such as that shown against astronomy in the sixteenth century, physiology in the seventeenth, chemistry in the eighteenth and biology in the nineteenth, we can begin to understand why this modern discovery about man himself should arouse such violent protest and alarm. The findings of psychoanalytical psychology are the keys with which the major barriers to progress in our educational system can be unlocked and when these insights are applied to the teachers in our schools, we will enter upon an era of human progress in which we may expect to solve some of the baffling problems which now beset our civilization. In addition to mental hygiene clinics for children, I advocate mental hygiene clinics for teachers. The therapy of personality problems in the child includes treatment of the parents as well, and I have often wondered why, in the elementary school era, the management of children's difficulties has not also focused its attentions upon the teachers, who are strong parental figures. It has occurred to me that one of the main reasons why these steps have not been taken is traceable to the lack of recognition of the most important

function of the educational process, which in the elementary school period should be an effort to correct mistakes made by parents and to work with them toward a better socialization of the child.

Teaching has immemorially been a lofty calling. It will always be one of the noblest of human activities to assist the young on their successful way through life. Once calling to itself the finest minds of the age, who were also philosophers and students, it has now become differentiated into those who pursue knowledge for the benefit of mankind and those who inculcate this heritage. It is a very sad reflection upon the general intelligence that the teaching of accumulated knowledge has been permitted to approximate routine craftsmanship. This has come about because of our ignorance of personality growth and our emphasis on material success. The amount of human wastage that can be charged to our educational system is inestimable but certainly very great. By the large majority in our society, education is conceived of as merely the acquisition of knowledge of various subjects taught in our institutions of learning and we are familiar with the fact that the primary goal of the educational system seems to be in this direction.

The student of personality regards preoccupation with these matters as of secondary importance and is inclined to the view that the fundamental problem of education is the study of human nature and culture. We are beginning to see this. It is a great misfortune that the teachers in the course of their training are not provided with the realization that self-knowledge and the awareness of the effects of themselves upon others constitutes the most precious information that they can possibly possess. It is a grave mistake that those in charge of our normal schools do not require the future teacher to have attained a satisfactory emotional maturity and that they make no effort to acquaint themselves with the inner lives of these persons nor the manner in which they live with others outside the school. As a result of this neglect, many severely neurotic, of whom some are destined to later suffer grave mental illness, are granted the responsibility of teaching the young. In the same manner that unhappy and emotionally conflicted parents unwittingly provide their offspring with unhealthy development of their personalities, so mal-

adjusted teachers unknowingly interfere with or do actual damage to the emotional growth of the children whom they teach.

A teacher was unduly worried about the safety of her pupils when they leaned on the window sills of her first floor classroom and she regularly felt compelled to count them when they returned from the recess period. Although she knew there was "no sense" to her near panic about their safety, she had not been able to overcome it and as her trouble seemed to be getting worse instead of better, she sometimes thought she might be losing her mind. To explain in detail the origin of these morbid fears and to describe how she was relieved of them might be of interest, but the more important aspect of her problem can be described as follows: She thought no one else knew about her apprehensions, and strictly speaking, she was correct. She did not know that some of her pupils who had seemingly liked to go to school when they were in the previous grade were now complaining at home about how cross their teacher seemed to be and how hard their studies were. She did not know that others had told their parents that when they recited, she often did not seem to be paying attention to what they were saying and that they thought she was rather queer. The parents had paid slight heed to their complaints, thinking the children themselves were just complaining. The school authorities knew nothing of this teacher's inner psychic distress and its serious reverberations in the lives of her pupils. To one who had opportunity to appraise the total situation, it was evident that her suffering was interfering with the academic progress of the children and that they were made unhappy and felt unfairly treated by her. The effect of this upon their future development cannot be estimated, but their experiences with her were unhealthy and might have been prevented had the educational system recognized one of its most important functions. An active mental hygiene clinic functioning as part of the normal school process could detect pathological aspects in teachers' personalities and in many instances through psychotherapy, these unhealthy tendencies could be eliminated. In other instances, the prospective teacher might be advised to engage in other work more suitable to her character. A mental hygiene clinic would make the training of teachers a more intelligent procedure than the one now being pur-

sued and would assure the children who go to school better opportunities than they now receive.

A fourteen-year old girl was referred to the mental hygiene clinic because she was failing in her studies and no longer showed much interest in her companions and her family. Her mother thought she might be brooding about something and remarked that she was inclined to spend much time alone in her room. Her daughter had denied worrying about anything. In the course of the psychiatric investigation, she told of her great fondness for her school teacher and the happy relationship she had had with her. She added that during the previous three months she had worried considerably because the teacher seemed to be "all upset about something" and "different." She had been afraid to talk to her mother about this unhappiness because she really loved her teacher more than her mother and was afraid this might be discovered. When her teacher was interviewed, she said she knew of no change in her attitude toward this pupil and thought the child's difficulties might be related to the onset of puberty and to the fact that the curriculum had become more difficult. Further conversation with her, however, revealed that she had been quite depressed by an unfortunate episode in her social life and that since then her duties as a teacher had been especially difficult for her. She remarked that "this trouble" was constantly in her mind but she had tried her best not to let it interfere with her classroom activity. She was told that she had evidently not been able to hide her feelings from at least one of her pupils who had come to feel so concerned about her welfare. When she came to understand how her own unhappiness had affected her pupil, she was quite astonished. As she improved under treatment and had talked somewhat frankly with the fourteen-year old girl, the mother reported that her daughter seemed like herself again and was doing much better in her studies.

There is ample justification for referring to our time as the century of progress. On the other hand, we must not be unmindful of the significance of modern crime, mental disorder, domestic disharmony and public insecurity. When we attend to the situation before us, it becomes evident that our remarkable achievements of the last quarter century are but a suggestion of the possibil-



ities of human accomplishments. We see that in some ways we are quite as far from the good life as the Greeks at the time of Pericles. It is not some great fundamental change that is indicated but rather an intelligent appreciation of those neglected factors that have brought about the unfavorable conditions in our civilization.

To the psychiatrist who is called upon for advice after social crimes have already been committed, who is asked to give counsel when marriages are on the verge of being smashed, and who is summoned to take charge when grave mental disorder has already rendered splendid personalities totally unfit for a continuation of their life's work, it often seems evident that the tragedies could have been prevented if the importance of certain types of behavior which had appeared earlier in the career could have been recognized as serious by their teachers. It is much easier to modify a personality in the course of its development, but the value of this in terms of the long-time objective has not yet been adequately perceived by a sufficiently large number. Let me illustrate this with a thumbnail sketch of a boy, nineteen years old, the only son of a family in the more privileged group of our society. It might have been noticed that he was suffering some pernicious influence before he was three years old. He was very difficult in some respects but he was very intelligent. With the exception of mathematics, his scholarship was really notable and his family looked forward to his distinguishing himself intellectually. By his sophomore year at the University, his behavior had become so peculiar that he was seen by a psychiatrist and discovered to be gravely affected by schizophrenia. By extraordinary good fortune he received mental hospital care that was actually effective in that it accomplished his restoration to *approximate* mental health. In this last particular, his case is unusual. Aside from that, he is but one of a great many of our really talented young people. Is it not a sad reflection on American education that neither in his home nor in the course of the many years spent in his schooling, did this brilliant boy encounter the experience or receive the kind of education that was necessary to enable him to live in the world of people as he found them; that he had to undergo a serious disorganization of his personality and pass through a mental hospital to find what

he needed? It goes without saying that the career in which this young man started will never be finished. Those who set out along a path that takes them through schizophrenia are usually content if they can regain their mental health. They have learned what so few of us appreciate: that to live intimately with a few people is a great achievement in comparison with which any neurotic goal is unattractive. Had they been soundly educated in the home and in the elementary and secondary school, this fundamental capacity for living with others would have come easily and their fine abilities could have been conserved for more generally useful goals.

The school is one of the oldest institutions in our society, and as such has always maintained the respect and confidence of the most conservative. Its principles and its promulgations have constituted standards for the great majority and parents generally have always hoped and expected it would somehow assist them in the training of their children and to remedy unsatisfactory behavior which they did not understand and which they could not correct. In many instances their expectations have been realized through the good influence of well-adjusted teachers.

The courses in mental hygiene and child psychology which many teachers pursue are undoubtedly worthwhile. The acquisition of information about the psychic life of the child provides them with some understanding of the child's needs, the nature of his impulses and the significance of his behavior. The dissemination of this data should be encouraged by every means at our disposal but we must be mindful of the fact that this is only the first step in our attempt to improve the general methods of education and that if we go no further than this, we will fail to accomplish for our children that which will do them the most enduring good. Very often persons are unable to utilize in interpersonal relationships the information obtained from lectures and books. No amount of psychological reading or pursuance of lecture courses can alter the past experiences of the neurotic teacher which so largely determine her attitude toward her pupils.

In their homes, children's relationships with their parents are frequently fraught with misunderstandings, much conflict and unhappiness. In the school, their opportuni-

ties for developing more healthy relationships with their teachers are frequently denied them because the mental status of the educators is no improvement over that of their parents. In some instances, that which they find in the school is more detrimental to their personality growth than that which they have encountered in their homes.

By these fragmentary allusions I hope to focus your attention on the gravest of the defects in our educational system. If we

could have as teachers only well-adjusted persons of dull intelligence, the group of healthy personalities emerging from our schools would be greatly multiplied. If we could have as teachers those who in addition to all the pedagogy that they bring, were also well-adjusted persons, I cannot imagine how great a stride each generation would take ahead of the last. The improvement that this would bring about is literally unthinkable.

## MEDICAL PRESS RELATIONS\*

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At the last meeting of the American Medical Association in Atlantic City there was introduced a resolution calling for the establishment in the American Medical Association of a department of public relations, with a trained public relations counsel in charge. Although this resolution was side-tracked, it indicated a healthy viewpoint on the part of many of the component organizations of the A.M.A.

At no time in the history of organized medicine is the need of adequate public relations so important to the future of the medical profession, and, I might add, the American people, as the present time. The trend of the times, whether we like it or not, is toward more and more government control of a vast majority of the functions of society, both economic and otherwise. Recent bills introduced in Congress, plus the talk made by Senator J. Hamilton Lewis, of Illinois, in the House of Delegates in Atlantic City last June, need only be mentioned to convince the most skeptical that the medical profession cannot afford to sit back and complacently rest on its high code of ethics and the brilliant pages in history which it has written in the past, under the private system of practicing medicine. The recent publicity given the announcement of the Committee of 430 but adds emphasis to the growing need of more adequate public and press relations.

Last October there was held a Science Writers' Conference in Chicago, full details of which have been published in the January 1 and 8 issues of the *A.M.A. Journal*. To me, one of the most startling discoveries of that conference was that there are so few newspaper reporters in the country who are competent to write and handle medical and public health stories.

Since it is recognized that more adequate

medical and public health press relations are needed if the public is to be honestly and intelligently informed on those professions, which are too closely allied to be considered separately, combined with the fact that the American Association of Science Writers see a lack of trained personnel in newspaper offices to handle such information, the first step toward a correction of these situations is clear. We must create more trained medical and public health writers, and, we must give them all the facilities necessary to enable them to interpret to the lay reader and the public generally, the accomplishments, problems, services and needs of medicine and public health.

Before discussing the training of a greater number of medical writers, let us consider the position the medical profession now occupies in the minds of the lay public and the average newspaperman. In spite of the almost breath-taking progress made by medical science in the past few decades, in regard to public relations, the profession stands almost in the same position as it did a century or so ago. No profession that has a direct contact with the public is surrounded by more mystery today than that of medicine. To the layman your terminol-

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ogy is something almost akin to the mysterious jumbo of the medicine man of the Indians or the tribes of inner Africa. That factor alone creates a condition that makes the problem of organized medicine's public relations much more complicated than those of any other profession.

Law has its special terminology but constant use of it in the lay press has made the average layman familiar with the unusual terms. Constant use of some medical terms have made them familiar to a large number of laymen. But, lay down on a table, side by side, a paper in a law journal and one in a medical journal and the average layman will get the gist of the legal discussion but will throw up his hands in despair at the medical.

If the medical profession is to combat socialized medicine effectively it must do so *through public opinion*. Some legislators, however, vote as they think best, regardless of public opinion, but most congressmen, or state legislators or city councilmen, are carefully checking on public opinion "back home" before they decide what their stand will be on this or that subject.

An organized minority frequently wins against an unorganized majority in our legislative activities in this country. While it is true that medicine is organized, it has been in the past and still is, to a vast extent, inarticulate. The voice of American medicine must be heard in every corner of the land, not in a roar of approval or disapproval of this or that measure, but in a frank, honest, calm and confidence-begetting quiet manner, in just the same way you talk to your patients at the bedside. The public must be taken into your confidence in a quiet way if they are to understand fully what your problems are.

I said that organized medicine is inarticulate. Here is an illustration of what I mean. Organized medicine and its friends talk constantly of the unselfishness of the profession, of patient after patient who is treated and cured without any compensation (or thought of same), by his physician; of the hour after hour a doctor spends pitting his brain and skill against death, sometimes losing, more frequently winning when given half a chance to do so, and knowing all the time that he won't get enough money out of the case to pay for his gasoline. They speak of the men of medicine who la-

bor year after year over test tubes in laboratories, seeking new truths in medical science, fighting unselfishly to increase the number of weapons with which to fight the ravages of nature.

All of this is true, and more so than the average layman realizes. But, when the question of socialized medicine is raised, the profession's chief argument against it, in the laymen's mind, is that it will destroy the initiative of the individual physician, that it will destroy the personal relationship between the doctor and patient. If that is true, and I don't say it isn't, then explain all of the unselfish work I described a minute or so ago. Reconcile these two statements for me.

Yes, I can reconcile them, to a certain extent, because I understand your profession better than the average layman does, but the man in the street cannot reconcile them. He says that in the last analysis you are the same as anyone else, that your opposition to socialized medicine is based on selfish interests. Well, between you and me, that is partly true, but far from the extent to which the layman thinks.

Behold the irregular practitioner. Does he have any trouble getting his stories across to the public? Well, perhaps he doesn't have as easy a time now as in the past, due to a closer coöperation between the medical and public health professions and the press, and even the radio to some, but, unfortunately, a much less extent. Why can't you do the same thing? Well, you can, and must! But, you ask, how? Through even closer coöperation than now exists between your medical societies and the press, for example. "All right," you say, "go ahead, we're with you." And then the very first time I try to write a story on, we'll say, dermatology for example, and want to quote someone who is an authority on that branch of medicine, I run into stone walls. It's unethical, I'm told, to publicize oneself in the medical profession. And if I do get someone to let me quote him, then his colleagues raise hob with him for it and, in some cases, he is threatened with expulsion from the medical society.

A year ago last fall I ran a series of fourteen articles in *The Free Press* on the health factors of middle age. Time after time I was forced to quote Dr. Don W. Gudakunst, our new State Health Commis-

sioner, who, fortunately, is a physician as well as a health officer, to give my articles weight enough to command the respect and confidence of the reader, and to quote him at times simply because I couldn't find any other reputable physician, specialist or otherwise, in Detroit, who was willing to be quoted. In one instance Dr. Gudakunst and myself obtained the cheerful help and guidance of a man outstanding in his particular field of medicine but we had to take his words and work them over and publish them as Dr. Gudakunst's statements because this specialist couldn't be quoted.

I know of feature story after feature story in this state that I can't write because to do so would place in jeopardy the ethical standing of the doctor involved. Yet every one of these stories contains in it a moral for the layman that would make him more fully appreciate the problems and the basic unselfishness of your profession. Every one of those stories would help build up in the minds of the public such a better understanding of the medical profession that eventually no legislator would dare advocate any kind of legislation infringing on the sacred rights of medicine.

Three decades ago medicine had the most effective public relations setup possible, in the days when most of the population was rural rather than urban, and the relationship between the doctors of America and the public was a close, intimate thing. In my home town everyone knew Doc. Kline, Doc. White, Doc. Pollock. Some didn't like one or the other of them but all of them were outstanding men in the community. When they drove their horses and buggies through the countryside on their constant errands of medical mercy and charity, their hands were being almost constantly waved at farm houses and farmers in the fields, as they passed. Their relationship with that community and the countryside was intimate and friendly. They represented the medical profession and their kindness and charity made the profession one of the most revered in the world. I stand here today, a product of the effective public relations work of those men. They taught me by their actions and conduct to hold doctors in the highest respect and almost in awe. I'm more than proud of having been asked to speak to you today. I'm proud, and humbly grateful, for the confidences that

have been placed in me by many members of your profession in this state, and elsewhere. I'm trying to dedicate myself to the same high purposes that those three doctors showed me when I was a boy.

But today the medical-practice picture has changed. Not only is the population predominately urban but the profession is different. In those old days there were few specialists, today there are row on row of offices in office buildings across the land which are occupied by specialists whose contact with their patients is brief and infrequent. Even the picture of the family doctor, or general practitioner, has changed to an amazing degree. People don't know a doctor today until they become ill, and all too frequently they lose contact with him after they are cured. Gone is the vast army of goodwill ambassadors of medicine, the old country doctor whose daily rounds constituted the most effective advertising campaign organized medicine ever had. You must find something to take his place and adequate press relations will go far in so doing.

Through a good press and public relations program you can make the public health-conscious, and that is exactly what you want. The medical profession can serve mankind more effectively and beneficially by keeping it well than by curing it.

Let the public become more familiar with your activities, some of your accomplishments, your programs and some of your problems. Make the healthy people of the country conscious of their need of you. A sick man isn't a difficult person to convince that he needs a doctor; a healthy man is. You're selling yourselves to sick people effectively but a sick man cannot raise a very loud howl of protest when some legislation inimical to the welfare of your profession is being agitated. A well man can shout loud and long, and take action if necessary, when his friends, the doctors, are threatened with some foolish piece of legislation or control. But, only if he has been sold on the fact that doctors are his friends and know what they are doing and how best to do it!

As an effort to accomplish this, and also to solve the problem of competent writers to tell the laymen about your profession, the State and the Kent County Medical Societies, with the coöperation of the new



State Commissioner of Health, are establishing something new in medical-press relations.

The city editors of the two daily newspapers in Grand Rapids, already approached on the plan, are enthusiastic about it. Each has appointed a reporter on the staff as a medical reporter, not to devote his full time to medical and health reporting, because only a few papers in the country can afford to do that.

Through the coöperation of the Kent County and Michigan State Medical Societies and the Michigan State Health Department, we are going to train the two reporters in medical writing; not to the extent that they will necessarily become experts, but at least enough so they will be competent to handle the medical and health material that comes to the attention of their papers. We are going to try and make them understand the ethics as well as the peculiar problems of the medical profession. We are going to teach them how to look up reference material and to translate your terms into lay English. We are going to endeavor to keep them informed as to what is new and good in medical and health activities, and what isn't new or what, for the public good, should be left unprinted. We hope eventually to reach the point where we will no longer have "upside down" stomach stories plastered on the front pages of their papers when such cases are in reality old stories in their community.

The medical profession in Kent County is going to take these men into their confidence and treat them the same way I'm treated in Detroit and elsewhere in Michigan and several other parts of the country. It is hoped that, eventually, this program can be extended so far as to include the entire country.

This program also can be worked out in your own communities. In some of your communities you can start it yourself, not necessarily by going to the city editor and asking him to appoint one, but by carefully studying the reporters on your papers and selecting one who you think will be interested in what the medical and public health field is doing, and then cultivating his friendship and according him the same confidence you want him to place in you.

When you are confronted with some sit-

uation that needs careful handling by the press, take a reporter into your confidence and tell him the entire story off the record and then go over with him what should be printed. Reporters as a whole are just as ethical in their work as you physicians are. They also are trained to dig out news. Much of that which goes into a real, live news story, is something that some person or other didn't want in the paper. The minute you start covering up something the reporter senses it and not infrequently he gets the information elsewhere and then you have no control over it.

I'll illustrate what I mean. A few years ago a certain hospital had one of its food handlers come down with what was at first diagnosed as typhoid fever. The superintendent, an M.D., and a friend of mine, phoned me and asked me to see him immediately. He told me the entire story. You simply cannot immunize all the employees of a large hospital against typhoid fever without it becoming known outside and a lot of questions being asked. Eventually it gets to the newspapers and the "news hounds" are immediately baying on the trail of a "hot story." In this case, I wrote a story that the employees of this hospital were being immunized against typhoid as part of a regular program of immunization that was being started in the hospital. The other two papers rewrote my story; none of the three stories was longer than three paragraphs and that is all that ever was written about that case.

Every reporter loves a feature story. Some of them cannot write one worth reading but they all think they can. Every city editor is constantly hunting for a feature story and raising hob with his staff if there isn't a constant flow of them over the city desk. If the story isn't well written he always can have a good writer rewrite it. Whenever you come in contact with an interesting story, get in touch with your reporter friends and tell them about it. Go over all the details and make sure you explain everything clearly to them. An unusual operation, the use of some new form of treatment (you call it therapy but to the man in the street it is just plain treatment), or any one of dozens of things happening all the time in medical circles, will provide a nice story for your reporter friends. They'll appreciate it, so will their city editor, and both will be much more willing to carry any

other story you may want some other time. Above all things, however, if there is more than one newspaper in your city, see to it that both papers get the story at the same time.

These are a few of the things you can do to help make the newspapers in your

home communities want to print stories about the medical profession that will do you good and will aid the reporters and editors present to the public the real story of the brilliant pages you men in the medical and public health field are writing on the pages of history.

## THE USE OF SULFANILAMIDE IN THE TREATMENT OF GONORRHEA

Report of Results in 175 Cases

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Even before the publication of a series of nineteen gonorrhea patients treated with sulfanilamide by Colston and Dees<sup>1</sup> the medical profession was startled by the optimistic verbal reports on the use of this drug. Urologists at first were very skeptical, owing to the frequency with which these new urinary antiseptics have been appearing the past few years, each one heralded with greater enthusiasm, even before its immediate predecessor has run its course. So with much skepticism I obtained small quantities of several different brands of the drug and proceeded as we have with so many previous "gonorrhea cures."

Following lay articles in such magazines as *Time*, etc., the country was "taken by storm" and it was very difficult to get enough of the drug to carry on our work. However, through the courtesy of Parke, Davis & Co., ample supplies have been furnished so that we have had 175 patients on this treatment sufficiently long, to make at least a preliminary evaluation of our results.

At first we selected only acute anterior cases and carefully examined them at each visit as to character of discharge, turbidity of urine, absence or presence of general symptoms, and reaction to the drug. Because these few selected patients did so marvellously it was thought that probably the results had been due to the fact that only the intelligent and higher type of patient had inadvertently been selected and because of the better type of hygienic care to be expected in such persons, our results were thus influenced.

So a new group was then selected merely in rotation as they appeared at the clinic. No attempt was made to select acute anterior, posterior or chronic cases. This group did as well, and so much better than could be expected in a clinic of this type, such as is found in the downtown district of a large metropolitan area. Because of the apparent lack of complications developing in either

of these small series of cases, another group of patients already suffering from complications was selected to see if it could be determined as to the value of the drug after such complications had occurred during other methods of treatment. Consequently in this latter series were placed 17 patients with subacute and chronic prostatitis, 4 patients with acute prostatitis, 11 patients with epididymitis, 4 with arthritis, four with prostatic-vesiculitis, et cetera.

In the male group there were 100 men with acute or chronic anterior urethritis that have received sulfanilamide in various dosages since May 18, 1937. In most of these 100 patients, sulfanilamide internally was the only treatment received. In only sixteen instances was it thought advisable to supplement the internal treatment with the use of local measures such as protargol injections. In only nine instances was other internal treatment as urinary sedatives deemed necessary. In these nine cases the use of a mixture of potassium citrate, Tr. Hyoscyamus and Tr. Belladonna was more comfortable to the patient. In this series of 100 patients the only complications noted were almost entirely due to the affects produced by the drug and not due to the further spread of the disease.

In sixteen instances where the drug was not well tolerated and the patient had not



received treatment long enough to be improved, the routine clinic treatment was instituted. Fifty-four of these patients have been discharged as probably cured. These have been discharged after clinical symptoms have disappeared, urine was clear, and after five consecutive negative smears, after prostate massage, have been obtained. As these smears are taken only at weekly intervals, thirty-five days is added to the length of treatment statistics. However, of the fifty-four patients in this male gonorrhea group that have been discharged as probably cured the average stay in the clinic was 45.7 days. When this is compared with the regular stay in the clinic of 92.05 days for male gonorrhea patients, the improvement is very apparent. In a series of 200 patients with gonorrheal filtrate plus regular treatment, if thought necessary, a similar average stay in the clinic of seventy-seven days was noted.

A close examination of the records of the forty-eight discharged patients reveals that the slides first became negative as follows:

## Acute Cases—32

1.....2nd day	1.....11th day
8.....3rd day	1.....12th day
1.....4th day	2.....13th day
3.....5th day	1.....19th day
2.....6th day	2.....22nd day
1.....7th day	2.....23rd day
3.....8th day	1.....25th day
2.....9th day	1.....30th day

## Chronic Cases—16

3.....3rd day	1.....11th day
1.....4th day	1.....15th day
1.....5th day	1.....16th day
1.....6th day	1.....18th day
1.....7th day	1.....20th day
4.....8th day	
1.....9th day	

Much discussion has occurred as to the dosage of the drug required. Some workers have felt that a large dose should be given at first, this to be gradually tapered off. Some have endeavored to increase the tolerance by just reversing the above method. We have tried several methods of varying doses in an effort to see if we could arrive at any satisfactory method but as yet have no definite conclusions to make. In the above series, patients were given three 5 gr. tablets four times daily for five days or 60 grains daily for five days then 40 grains daily for seven days and then 20 grains daily for seven days. In the female cases to be reported, the dosage of the drug was much less, being as follows: 60 grains the first day, 40 grains daily for the next four

days and 20 grains daily for the next ten days.

Some relapses have been noted during treatment, especially in the male patients, but in only five instances was it deemed advisable to discontinue the sulfanilamide treatment due to this cause. These were after twenty-nine to forty-nine days of uneventful treatment. In a later series of twenty-five male cases still under observation, *seventeen* tested negative slides after nine days of treatment. In this latter series the dosage was much higher than in the previous similar series. In four instances no improvement at all was noted in clinical signs such as urethral discharge; one of these was seen every other day for nineteen days and received during this time 79.4 grams of the drug and slides were consistently positive; as follows:

*Case 1.*—A white male, aged twenty-six years, was admitted to the clinic with acute gonorrheal urethritis May 20, 1937. History has shown no previous attacks of gonorrhea. He was placed on sulfanilamide, 5 grains four times daily for two days, then given 45 grains daily for four days, then 30 grains daily for two days, then 60 grains daily for seven days, 40 grains daily for seven days and 30 grains daily for another seven days. He was observed every other day and slides were consistently positive for the gonococcus. He was returned to the regular clinic for the usual routine treatment.

*Case 2.*—A white male, aged forty-six, was admitted to the clinic May 19, 1937, with acute gonorrheal urethritis. History showed there had been no previous attacks. He was given sulfanilamide as follows: 80 grains daily for five days; 120 grains daily for two days; 80 grains daily for two days; 60 grains daily for four days; 15 grains daily for four days; 20 grains daily for five days; 25 grains daily for five days.

Urethral smears were consistently positive for the gonococcus with continued heavy purulent discharge. No improvement being noted at the end of thirty-one days, he was returned to the regular clinic with satisfactory response to routine treatment.

On the other hand, some patients were selected because of inability to respond to the regular routine clinic treatment and results were marvelous in several instances, as follows:

*Case 3.*—A white male, aged twenty-six, was placed on sulfanilamide treatment after having been treated for twenty-seven weeks for acute gonorrheal urethritis. Smears still showed gonococcus to be present. After 40 grains daily for seven days of sulfanilamide treatment, urines were clear and slide was negative for gonococcus. The sulfanilamide was continued as follows: 40 grains daily for seven days, 20 grains daily for twelve days. Urine remained clear and slides after prostate massage remained consistently negative until discharged, eight weeks after beginning of sulfanilamide treatment.

In the female patients, so far the results have been much better than in the male. This was especially noted in a series of patients interned at our hospital service for venereal diseases in women. Fifty patients in this series have been treated with sulfanilamide and forty of these have been discharged as probably cured following hospitalization of from fifteen to thirty-seven days. Forty of these had acute gonorrhea as follows: Urethral smears positive, thirteen patients; cervical smears positive, twenty patients; urethral vaginal and cervical positive, five patients. The course of treatment given this series was 60 grains the first day, 40 grains daily for the next four days and 20 grains daily for the next ten days. Negative slides were obtained as follows:

Number of Patients	Duration of Sulfanilamide Treatment
14	3
12	4
6	6
7	8
1	13
1	20

Five consecutive negative slides must be obtained from urethra, cervix and vagina before these patients are discharged. The minimum period was fifteen days and the maximum was thirty-seven days as follows:

Number of Cases—41

1.....11th day	4.....24th day
1.....13th day	2.....25th day
1.....15th day	4.....25th day
2.....17th day	3.....25th day
1.....20th day	2.....25th day
2.....21st day	2.....25th day
5.....22nd day	1.....25th day
2.....23rd day	3.....25th day
	4.....25th day
	1.....25th day

Only two patients showed positive slides after slides were begun. This was on the fifth and tenth day of sulfanilamide treatment, but five negatives were obtained by the twenty-fourth day, respectively.

In the female ambulatory clinic the drug was also used. Negative slides were obtained as early as the sixth day and patients discharged after five consecutive negative slides, as early as the twenty-first day.

We have had some experience in the use of sulfanilamide in gonorrheal vaginitis in children. This condition has always proven a very stubborn one, and although our series is very small, results are encouraging enough to warrant its use in these unfortunate children. A few cases are as follows:

*Case 4.*—A white girl, aged six years, was admitted with gonorrheal vaginitis on March 29, 1937. The rectal and vaginal smears were positive. On August 3, sulfanilamide treatment consisting of thirty-one tablets (155 grains) was given over a period of fifteen days. The rectal and vaginal slides have all returned negative since August 10. The last slides were taken September 21, 1937.

The child had a considerable amount of vaginal discharge and frequent defecations, eight to ten times a day, before sulfanilamide was given. The mother now states that the stools have been normal since the third day of sulfanilamide treatments, and there is no vaginal discharge seen.

*Case 5.*—A white girl, aged three and a half years, was admitted to the clinic on January 13, 1937. She had gonorrheal vaginitis with profuse purulent vaginal discharge, the smear from which showed gonococcus present. There were urinary symptoms of frequency and burning, and the urine specimen showed many pus cells and red blood cells present. The patient was discharged from active treatment after five negative smears on June first, although the mother claimed the child had vaginal discharge occasionally.

The patient returned on August 3, when a smear was found positive. Sulfanilamide treatment was started on August 18, and the patient was given twenty-one tablets (105 grains) over fifteen days. She had had negative smears weekly since August 24, and has had no vaginal discharge nor irritation. The mother says the child "acts" better than she has since the first time she was treated.

*Case 6.*—A white girl, aged four years, was admitted June 17, 1937, with gonorrheal vaginitis. On August 19, 1937, a smear was positive, and there was a small amount of vaginal discharge. On September 3, 1937, the child completed a course of sulfanilamide of twenty-one tablets (105 grains) over a period of fifteen days. The smears were negative while taking the sulfanilamide. The case record is as follows: On September 13, 1937, the smear was positive with a large amount of vaginal discharge; on September 16, 1937, the smear was positive with both vaginal and rectal discharge. On September 20, 1937, the patient completed a second course of sulfanilamide of eight tablets (50 grains) over a four-day period. The vaginal smear was positive, and the rectal smear was negative. The patient is now on the third course of sulfanilamide of ten tablets (50 grains) over a ten-day period. On September 23, 1937, the smears were negative, but there was a discharge.

*Case 7.*—A white girl, aged four years, was admitted on March 19, 1937, with gonorrheal vaginitis with profuse purulent discharge and signs of much irritation around the introitus. The smear was positive for gonococcus. The child was given a course of sulfanilamide of thirty-one tablets over a fifteen day period (155 grains). The smears have been negative since August 26, 1937. The discharge disappeared after two days of sulfanilamide. Some irritation and a slight amount of discharge was present on September 9, 1937, but negative smears are still being obtained.

In the total number of 175 patients who had received various amounts of the drug, reactions were noted in twelve patients. Most of these were of minor importance and subsided at once on withdrawal of the drug. The commonest complaints were those of headache, extreme lassitude and



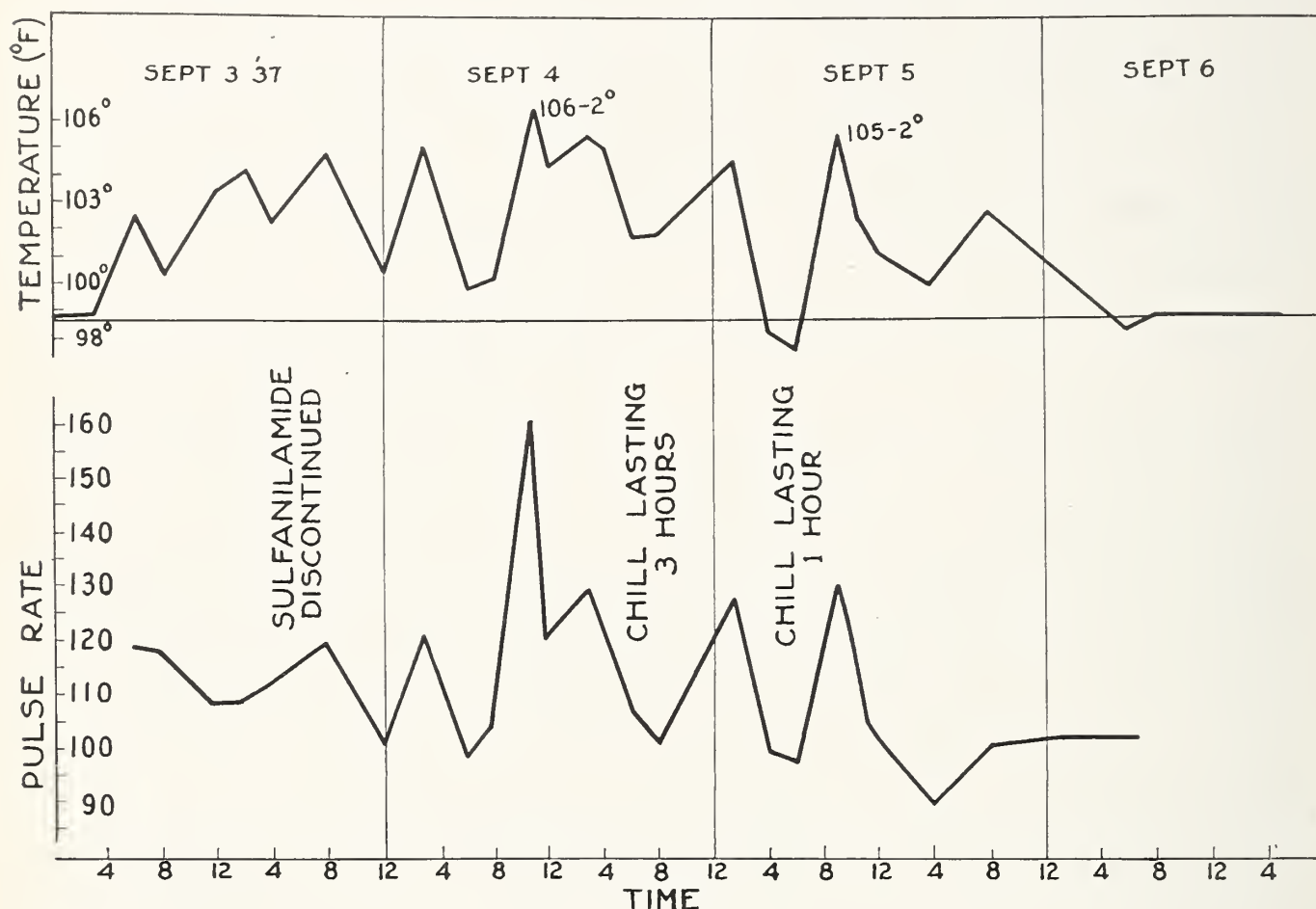
general malaise. Some of the male patients complained of disturbing dreams with sexual disturbances not explainable by the activity of the gonorrhea present, and these symptoms would cease if and when the drug were discontinued. In only one of our entire 175 patients was a severe reaction noted. This was a female at the Annex Hospital whose temperature curve became quite disturbing.

dosage to suit the patient will be worked out.

### Conclusions

A series of 175 gonorrhea patients of various age groups, both male and female, have been studied. All patients were picked at random rather than by selection.

In the male adults, results were better than in previous methods of treatment, almost invariably as to shortened time of



I have seen severe dermatitis following the indiscriminate use of the drug by self-medication, but not in our series. In this instance the patient had not returned to his physician for over a month and continued to use the drug himself in large doses without paying any attention to preliminary symptoms of intolerance, as lassitude, itching, et cetera. A severe acute urticarial edema had occurred and was followed by intense exfoliative dermatitis with eventual recovery twenty-four days after the drug was discontinued.

However, any drug that has any beneficial reaction may likewise by indiscriminate use have untoward or even dangerous results. It is probable that as time goes on the particular types of gonorrhea where it is most applicable and some method of adjusting the

treatment necessary, and as to fewer complications, especially when no other treatment was used.

In the female adults, a decided improvement in results obtained was noted. The quarantine period necessary was almost halved. It has been noticeable at the hospital, where we have been accustomed to having a population of forty-five to fifty patients, that we now have about twenty-five to thirty, owing to a more rapid turnover, due to quicker results obtained since the routine use of the drug. No other changes in the treatment routine were made.

It was quite apparent that those female gonorrhea patients that were hospitalized responded much more favorably and quickly than did the small series of ambulatory patients. This was in spite of the fact that the

dosage in the ambulatory patients was usually considerably higher than in the hospital patients.

Whereas in the vast majority of patients the drug seems to have much value, nevertheless in a few exceptions it appeared to exert no benefit whatsoever. We are endeavoring to study these exceptions individually to see if better results can be obtained by variations in the dosage or whether other factors can be determined that might alter

the value of the drug. If so, we could know beforehand in which types of patients or in which manifestations of the disease this valuable drug is indicated or contraindicated. It certainly appears at this writing that the benefits already demonstrated by this drug in controlled cases are worthy of further use and study.

### Reference

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### Care of the Feet in Chronic Arthritis

JOHN G. KUHN, Boston (*Journal A. M. A.*, Oct. 2, 1937), contends that chronic arthritis in its early stages usually presents the same pedal symptoms which are caused by chronic strain. Differentiation can usually be made from the history of progressive impairment of the general health, involvement of other joints and stiffness of the feet after rest, which lessens with continued use. The swelling is variable in degree but more widespread and not limited to a special location. Limitation of motion in the midtarsal joints is one of the most common early symptoms. The blood sedimentation index is elevated in most instances. Roentgenograms, which usually show nothing abnormal at the onset of the disease except swelling of the soft tissues, show progressive bony atrophy, clouding of the joint spaces and increasing narrowing and irregularity of the articular surfaces. These symptoms and these changes in the feet will be observed in about three fourths of all patients with early chronic arthritis. The only certain method of preventing future disability is to avoid weight bearing until the pain and swelling in the feet subside. Before the patient again becomes ambulatory, proper shoes and adequate support should be given to prevent strain. If inadequate treatment or no treatment is given and the arthritis remains, increasing deformity usually occurs. The deformity most commonly seen is one with the foot stiff in valgus. Because weight bearing is faulty and because normal use of the intrinsic musculature of the foot is prevented, the muscles atrophy and a widening of the anterior part of the foot is seen, a flattening of the so-called anterior arch. This is followed by undue pressure on the heads of the metatarsal bones, and the symptoms are usually pain and tenderness. When this degree of deformity has come, disability is severe, and the patient usually walks with great difficulty. The severe strains, which come chiefly on the foot and the knee, aggravate the arthritis, and no subsidence of the inflammatory processes in the joints can be expected unless the deformity is corrected. When weakening of the intrinsic muscles of the feet and spreading of the forepart of the foot persist, two other deformities develop, hallux valgus and contracted toe deformity. Operative correction is not always necessary in the early stages of these deformities. Temporary cessation of weight bearing and exercises to develop the flexors of the toes and the intrinsic muscles of the forefoot will help greatly. The chief concern is

adequate support to the anterior part of the foot. When rigid deformity is present and the arthritis is inactive, a manipulation of the toes into flexion with the patient under anesthesia may be required. After the manipulation, the toes can be held in plantar flexion by adhesive strapping for several days. Repeated manipulations will at times result in normal function of the toes. When subluxation of the proximal phalanx persists and there is marked deformity of the joints, the most rapid and usually the most satisfactory result is obtained by the operative removal of the distal half of the proximal phalanx. If the hallux valgus is severe, operative correction by removing the proximal portion of the first phalanx of the great toe usually gives the best functional result. Extensive reshaping of deformed bones has not proved a desirable procedure. After operation, marked changes take place in the atrophied bones as the result of function. The simplest and least traumatic surgical procedure gives the best end result. Operative procedures are undertaken only when the arthritis is quiescent. Ankylosis of the phalanges is not commonly seen. When it has occurred, removal of the entire proximal phalanx has given painless function without the subsequent development of calluses under the toes. Hallux rigidus can frequently be relieved by a long plate or by greater rigidity in the sole of the shoe. Occasionally the ankylosis of the tarsal-metatarsal joints can be broken by manipulation, but usually an operation is required. The simplest procedure is removal of the proximal half inch of the metatarsal bone. Ankylosis in the tarsal joints rarely yields to manipulation. If a fair weight bearing position of the foot cannot be secured with proper shoes and foot plates, an operative correction of the deformity is indicated. The most useful procedure is a wedge osteotomy through the subastragalar joint or through the dorsum of the foot, with the foot held subsequently in a good weight bearing position while the site of the osteotomy heals. Spurs are frequently found in feet troubled by arthritis. When a proper weight bearing position of the foot has been obtained and the foot strain has been relieved, the symptoms have disappeared in all but a few cases. A disability constantly associated with arthritic involvement of the feet is epidermomycosis. The infection yields readily to the usual remedies, but reinfection often occurs until the arthritis becomes quiescent and the circulation in the foot improves.



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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APRIL, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### FIGHT CANCER WITH KNOWLEDGE

THIS month has been designated as a special period for a nation-wide fight against cancer. While a fight against cancer should be waged for twelve months each year, a particular month set aside for an educational drive is to be commended and every physician and surgeon should coöperate. The Woman's Field Army have adopted a slogan, "Fight Cancer with Knowledge," which is very much to the point. During the past thirty years or more, we have learned a great deal about cancer in spite of the fact that no specific cure has yet been discovered. We mean "cure" in the sense that we have a cure for such diseases as syphilis, malaria or diphtheria. So much has been written on the subject that there is no excuse for ig-

norance on the part of any member of the medical profession. This knowledge, however, should be passed on. The "cure" for cancer is only effective when the disease is discovered early and the growth eradicated as soon as it is discovered. This means watchfulness on the part of everyone. Cancer in many instances is insidious in its beginning with few or no disturbing symptoms. The subject should be approached, not as an alarmist would approach it, but in the spirit of hope.

The Cancer Committee of the Michigan State Medical Society have prepared for the Joint Committee on Public Health Education a brochure on the subject which tells about cancer in language which is easily understood by the average reader. This little brochure is authoritative as well as simple. Every doctor should possess a copy and should read it thoroughly so as to be able to present the subject in a clear way to those who consult him.

In this JOURNAL has already appeared a series of six articles\* prepared by the Cancer Committee on the general subject of what to do with the cancer patient. If the physician consulted is not immediately prepared, or for any reason does not feel competent, to care for these patients, it is his duty to see that they are referred either to a surgeon or to a roentgenologist who can give the necessary treatment.

On April 25 at 2:15 P. M., Dr. Carl V. Weller, professor of pathology of the University of Michigan, will address a public meeting in the ballroom of the Hotel Statler, Detroit. This meeting is free. The number present should be large, and it will be if every doctor who reads this announcement will assume the position of a committee of one to urge attendance. Let us help to the extent of fighting cancer with knowledge.

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### WHO MAY INTERPRET X-RAY FILMS?

THE *Detroit News* of March 11 contained a small item of news, probably of not much consequence to anyone else; it, however, caused some concern to the practicing roentgenologist inasmuch as it was purported to be a ruling of the attorney-

\*Journal of the Michigan State Medical Society, Vol. 34, page 789 (December, 1935), and Vol. 35, pages 48, 110, 193, 264 and 338 (January, February, March, April, and May, 1936).

general of the State of Michigan to the effect that lay persons might interpret x-ray films. Such a practice, of course, would lead to a deterioration of what has proved to be one of the most valuable diagnostic specialties. However, it is always well to wait for a more complete explanation before becoming too much alarmed. There is an old saying that if you ask a fool question, you will get a fool answer. Questions (three in number) were put to the attorney-general by an osteopath. This is a sample: "Is the taking of an x-ray picture the practice of osteopathic medicine, medicine or dentistry?" Of course, this could be answered very briefly, "No," but what significance would such an answer have? The term, "x-ray picture," is a misnomer, inasmuch as the only feature in common to a roentgenogram and a photograph is the fact that sensitive photographic films are used in each process. The x-ray tube is in no sense a camera. Furthermore, the making of radiographs even is in many instances the work of the non-medically trained technician.

In answer to the second question, "Is the interpretation of such roentgenograms for the purpose of diagnosis, practicing osteopathy, medicine or dentistry?" We claim that the interpretation of roentgenograms for the purpose of diagnosis is practicing medicine. The attorney-general answers, "It is our opinion that so far as used for diagnostic work, it is not necessarily confined to use by any one branch of the healing profession." This does not say anything about lay persons interpreting x-ray films. The attorney-general goes on to quote a judgment by the Minnesota Supreme Court:

As stated by the Minnesota Supreme Court in the case of *Henslin vs. Wheaton*, 91 Minn. 219; 64 L.R.A. 126:

"It (the x-ray) may be applied by any person having the requisite scientific knowledge of its properties and there would seem to be no reason why its application to the human body may not be explained by any person who understands it." (Italicized portion ours.)

*Any person who understands it.* The medical profession claims that this means, and can mean nothing else, that if applied to the human body, no one but the medically trained person and one trained to interpret findings from the viewpoint of density,

either increased or decreased, produced by disease, can possibly interpret x-ray films.

The attorney-general amplified this by the following statement: "To the extent, however, that such interpretation consists of making a diagnosis for a particular patient, it is the practice of the healing profession." Now, since the diagnosis is always connected with "a particular patient," we think the attorney-general has given very good answers to somewhat vague questions.

### THE CITADEL

A NUMBER of physicians have found a story writing more remunerative and more congenial than the practice of medicine. Among the number may be mentioned Warwick Deeping, Francis Brett Young, Somerset Maugham and A. J. Cronin. The last named is much in the limelight at present as the author of "The Citadel." We have not yet discovered the significance of the name of Cronin's book. It, however, is a story of the career of a young doctor who began to practice in a mining district, married, shifted to several locations and finally moved to the English metropolis. The setting is in Wales and England, and the chief *dramatis persona* is a young graduate of a Scottish medical school.

We will not recapitulate the story since the human interest lies not so much in plots and outlines as in the manner of telling. Thomas Carlyle once said, "A true delineation of the smallest man and his scene of pilgrimage through life is capable of interesting the greatest man. Each life is a strange emblem of every man's and human portraits faithfully drawn are of all pictures the welcomest on human walls."

The popularity of "The Citadel" and "The Stars Looked Down," and other works by Cronin, is due to the author's unique ability to make his characters real live persons. "The Citadel" has been so widely read that any comment would be superfluous. We cannot see, however, how it adds to the interest of the story for any author to go out of his way to criticize adversely the profession of which he happens to be a member. All the learned professions are composed of men and women among whom, if a search be made, black sheep may be found. The black sheep, however, is so rare that he is apt to be conspicuous out of all proportion to his importance. Cronin's story would



have had even a wider appeal if the muck-raking features were subordinated or eliminated altogether.

### TAXES ARE UNPOPULAR

AT a recent poll of opinion, eighty-seven per cent opposed an income tax on incomes less than \$1,000 for a single person and eighty per cent opposed tax on less than \$2,500 incomes for married persons. As it is, only one in every twenty-four adults in the United States pays income tax. There is not much in this to surprise us, and yet most of those who do not pay a direct income tax do not go free. Much ado is made in this state over the imposition of a small sales tax which is about the smallest tax anyone pays. A tax of twenty to thirty per cent may be placed upon gasoline for instance; it is computed in with the price of the article and no one gives it any consideration.

The old-fashioned ideas of industry and thrift, especially thrift, seem to have vanished to a large extent from the twentieth century mind. If it were possible to present the real cost of the article separate from the added taxes, consternation would result. Nothing will revive the old-fashioned virtues like making taxes stand out as the proverbial sore thumb.

### WHEN AH HEAR THE FROGS ASINGING

You may not think it's music, you may not think  
it's song,  
You may not think it worthy of your listening very  
long,  
Bit I'm enchanted and delighted and ma hert is  
verra light  
When ah hear the frogs asinging, asinging in the  
night.

Oh, it's often that I wonder and I wonder ardently  
What the world wid hold in rapture to encompass  
you and me,  
What the nightly hours would render in their  
slowly passing flight  
If there were no frogs asinging, asinging in the  
night.

When I'm lying in the hammock wi' ma face intil  
the sky  
Wi' thae hours long and dreary as the clouds are  
rolling by,  
Ah am charmed beyond all measure and my mind is  
'live and bright  
If I hear the frogs asinging, asinging in the night.

Oh, I want to live and listen in the quiet and  
darkening hour  
With the spreading oaks above me as a mighty,  
wondrous bower,  
And the murmuring leaves asighing, and the moon-  
beams out of sight,  
If the frogs are still asinging, asinging in the night.

WEELUM

### Malunited Colles' Fractures

WILLIS C. CAMPBELL, Memphis, Tenn., (*Journal A. M. A.*, Oct. 2, 1937), points out that two entirely different surgical principles may be employed in malunited fractures: one restoring function by a compensatory procedure, the other by reconstructing normal anatomic relationships. The most efficient procedure of the bone whereby the normal angle of the articular surface is restored, the radial shortening corrected and the prominence of the distal end of the ulna removed, thus reproducing normal external and bony contour. The technic of the operation is as follows: A lateral incision is made over the lower extremity of the radius about 2 inches in length through the skin and superficial fascia between the brachioradialis and the abductor pollicis longus and the extensor pollicis brevis. The line of fracture is exposed. A transverse osteotomy is made through the radius about three-fourths inch to an inch above the distal articular surface, after which correction of the posterior angulation of the lower fragment can be made by acute flexion of the wrist so that the lower fragment is angulated slightly downward and forward. In this position, a hemostat can be inserted between the fragments and opened with moderate force, thus separating the fracture surfaces and demonstrating the amount of increase that can be obtained in the length of this bone. A skin clip is now placed so as to close this wound temporarily. An incision is then made for about 2 inches over the medial aspect of the lower extremity of the ulna through the periosteum, which is stripped off of the inner half from above downward, exposing the articular surface and the styloid process. With a small osteotome the inner half or third of the head and inner portion of the shaft is severed from below upward, thus securing a free graft of bone about 1 inch in length and about one-half inch in thickness at one extremity and tapered at the other. The free graft of bone is trimmed to make a pyramidal wedge with a base on the dorsal as well as the lateral aspect, which is inserted into the space between the fragments. The dorsal wedge maintains the normal angle; the lateral wedge prevents recurrence of radial shortening. Care must be taken that there is slight overreduction of the lower fragment; that is, slight anterior angulation. Both wounds are then closed and dressed with small gauze pads. On inspection the external contour should be approximately normal except that the head of the ulna may not be prominent. The lateral dimension or width of the wrist should be normal, and on palpation the lower extremity of the styloid process of the radius should be distal to that of the lower extremity of the ulna. A sterile flannel bandage is placed from the metacarpophalangeal joints below to just above the elbow, and the sugar tong cast or molded plaster anterior and posterior splints are applied. While this is consolidating, the forearm is held in midposition, the wrist in slight flexion, with pressure over the dorsum of the wrist so as to make the posterior capsule of the wrist joint tense, thus maintaining the lower fragment of the radius. A roentgenogram is then made which should demonstrate practically normal anatomic alinement. Surgical procedures have been carried out in forty-one of malunited Colles' fractures; twenty-two were simple osteotomies of the radius; nineteen were plastic procedures on the bone as described. A reasonably high percentage of function was restored by osteotomy alone, but the radial shortening and prominence of the ulna were not corrected. The results from the plastic procedure on the bone have been uniformly excellent, meaning that the contour is approximately normal and function restored to a material degree.

# President's Page

## HELP SUPPLY THE ANSWER

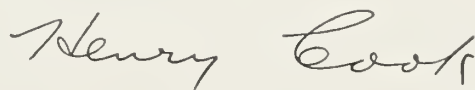
RECENT rumors and statements concerning the future of Medicine are such as to cause grave concern in the minds of thinking physicians and citizens. *News Week* informs us that "New deal leaders have drafted plans for a large scale national health program to be financed by the Federal Government"—this in the face of the frequently demonstrated inefficiency and incompetence of most local, state and federal administrations in the past, with the TVA a recent case in point: TVA with a larger and more expensive public health service than the whole state of Tennessee and Kentucky! (according to Congressman Andrew J. May of Kentucky).

Revolutionary change in medical practice is urged, in the main, by brains not medically trained or experienced. These individuals and groups are working on the premise that the present system of medical care has fallen down, not in quality but in distribution. Is this premise, that the distribution of medical care is inadequate, true or false? It is up to the medical profession to find out—NOW.

The American Medical Association survey, to be made in our 2,054 county medical societies of the nation, will supply the answer. It is extremely imperative that the profession of the state and country co-operate in this survey, that each county society study its own conditions, find out if anything needs to be done in the individual locality, and immediately do something about it.

It is to be hoped that every member of the profession will do his individual part to support his organization at this time since the welfare of the people demands that all progress and change in medicine shall be constructive. Progress in Medicine, as in all good things, is made by evolution, not by revolution.

Respectfully submitted,



President, Michigan State Medical Society.



## POSTGRADUATE PROGRAM FOR 1938

Michigan State Medical Society—University of Michigan—Wayne University

The Department of Postgraduate Medicine of the University of Michigan Medical School, in conjunction with the Wayne University College of Medicine and the Michigan State Medical Society, announces the following short, intensive postgraduate courses:

### Annual Spring Courses

Ann Arbor

University Hospital

Electrocardiographic Diagnosis	April 4-9
Ophthalmology and Otolaryngology	April 25-30
Diseases of Metabolism	May 16-18
Diseases of Blood and Blood-Forming Organs	May 18-20
Roentgenology	June 27-Aug. 5
Pathology (four courses of two weeks in special subjects)	June 27-Aug. 19
Laboratory Technic	June 27-Aug. 19
Summer Session Courses	June 27-Aug. 19

Detroit

Pediatrics (Henry Ford, Children's and Herman Kiefer Hospitals)	April 18, 19 and 20
General Medicine (Receiving and Herman Kiefer Hospitals)	April 18-22
Proctology (Receiving Hospital)	April 25, 26 and 27
Urology (Receiving Hospital)	April 28, 29 and 30
Obstetrics, Gynecology and Gynecological Pathology (Receiving and Herman Kiefer Hospitals)	May 2-6

Consult Your Bulletin for Details.

### Annual Autumn Courses

The following subjects will be presented in the autumn Extramural Courses:

#### Gynecology and Obstetrics

1. The management of hemorrhage in pregnancy.
2. Evaluation of methods of management of pelvic inflammatory disease.

#### Surgery

3. Demonstration of the treatment of varicose veins and ulcers of the leg. The early and late cases.
4. Care of fractures of long bones.
5. Abnormalities and diseases of male genital tract.

#### Internal Medicine

6. The differential diagnosis of persistent cough.
7. Methods for diagnosing fever of unknown origin.
8. The prognostic significance of the white blood cells in infections.
9. A rational classification of nephritis and principles in management of the nephridies.

10. The significance of the cardiac arrhythmias.
11. A demonstration of the newer important laboratory aids for office use.
12. The criteria for the diagnosis of tuberculosis.

#### Neurology and Psychiatry

13. The care of the aged person.
14. The importance of early recognition of mental disease. The physician's rôle in the statewide program for control of mental disease.

#### Dermatology and Syphilology

15. The newer methods of treatment of some common skin diseases.
16. Evaluation of the Kahn test in treatment of syphilis. Management of latent syphilis.

#### Pharmacology

17. The indications for use of certain drugs.

#### Centers

Ann Arbor  
Battle Creek-Kalamazoo  
Bay City  
Flint

Grand Rapids  
Lansing-Jackson  
Marquette  
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For further information, address:  
Department of Postgraduate Medicine  
University Hospital  
Ann Arbor, Michigan

# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## Council Chairman's

### - - - Communication

#### CONFIDENCE

DUE to recent newspaper articles the status of the Michigan State Medical Society relative to the state administration and the State Department of Health has been questionable.

Confidence, however, has been restored.

In a letter, dated March 16, Governor Murphy wrote to Dr. Henry Cook, president of the Michigan State Medical Society, that "a sound program based upon the fundamental American principles of practice of medicine, furthering the individual patient-physician relationship, can be solved."

This letter was written in regard to the Department of Health coöperating in the survey of the indigent when we make the A.M.A. survey.

The Governor of Michigan is to be commended in the appointment of Dr. Don W. Gudakunst to the Department of Health.

Dr. Gudakunst has stated that the Department of Health cannot function without the confidence and coöperation of the physicians of Michigan.

We have accepted his Faith.

We have yet to prove to the American Press that the American principles of the practice of medicine are honest and that the Michigan physicians are always working for better medical care and distribution of medical care in Michigan.

We hope to gain their confidence when our plan of better press relationship as instituted in Grand Rapids spreads over the state.

It is very gratifying to the officers of the Michigan State Medical Society in their contacts with the County Medical Societies, that its members are realizing that we must restore the public to its faith in the great American principles of the practice of medicine and the family physician.

Medical care can be given only by those licensed to practice medicine.

The Executive Committee of The Council urges you to read the advertisements and use coupons that offer samples and literature. The JOURNAL needs your coöperation.

All laws enacted in the 1937 legislature and changes in laws and the enforcement of the same proved to the 1937 legislature that the Doctors of Medicine had the protection of the health of the people of Michigan as their objec-

tive.

Do your part by lecturing to lay organizations that only the Doctor of Medicine can solve medical problems.

P. R. URMSTON, M.D.,  
*Chairman of the Council.*

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"All medical progress begins with **you**."

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#### SICKNESS

SICKNESS cannot be anticipated and the degree of its incidence is wholly unpredictable. The construction of highways and the building programs of governmental agencies can be planned and provided for with adequate funds. The appropriation of funds for the care of the sick can only be approximate. The allocation of a given amount of public funds for the care of the sick will in no way determine the incidence of that sickness. When sickness occurs it must be met, and, unlike a highway or building, it cannot be delayed or postponed.

The medical profession has no part in the creation of sickness. It alleviates pain and delays the inescapable scourge of death. It interests itself in seeing that care is given to those who unfortunately *do* get sick and, in



the case of public charges, attempts to conserve the allotted public funds for those who are deserving of tax-supported aid.

To this end the Michigan State Medical Society developed the *Filter System*, a mechanism whereby public funds would serve those sick children for whom they were intended. It did not guarantee that the incidence of sickness could be kept within conventional limits set by legislative enactment. It could not determine when and how much sickness would occur in a given biennium.

It is apparent, therefore, that appropriations for the care of the sick, such as Crippled and Afflicted Children, will often be inadequate; inadequate because sickness is unpredictable. Its incidence does not lend itself to exact legislative planning.

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"You are the M.S.M.S., Doctor."

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### "PUT IT IN THE PAY ENVELOPE"

THE last person in this country to seek socialized medicine should be the employed person, because he ought to recognize that it means *less wages and more taxes*.

The employed person should realize all too well that adequate living wages from which normal healthful living and competent medical care can be secured is to be preferred to insufficient income with inadequate clothing and food and unhealthful housing—all of which tend to bring on sickness. Sufficient food, fuel, warm clothing, and good housing would cut down illness. Most schemes of socialized medicine are but a poverty system substitute for the payment of adequate wages. The employed person usually prefers to purchase his own medical care and other necessities when and from whom he pleases in the true American way. His experience makes him suspicious of payment "in kind." With Samuel Gompers, he says: "Put it in the pay envelope and we'll buy our own welfare."

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"All medical progress begins with **you**."

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### "A TUBE A DAY EQUALS \$8,000 A YEAR!"

THE Laboratories of the State Department of Health report that one thousand containers are shipped to physicians every day, but that only about three-fourths of this total are returned. In other words, a loss of 250 specimen containers *per day* is experienced. This seriously hampers the

work of the State Department of Health laboratories, in its efforts to keep up with the increasing demands made by physicians for serologic and bacteriologic work.

Somewhere in a corner of your office, Doctor, there may be three or four or as many as a dozen idle containers. Please return these to the State Health laboratories, Lansing, as soon as you can, as there is urgent need for this glassware.

Statistics: Two hundred and fifty lost containers per day equals 6,750 per month, or 81,000 per annum. At ten cents each, this represents a loss in glassware of \$8,000!

Sending back your unused containers today will help tremendously. Many thanks.

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"You are the M.S.M.S., Doctor."

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### M.S.M.S. OBJECTIVES AND ACTIVITIES

#### I. Professional and Educational:

The Michigan State Medical Society and its component county societies bring you these valuable benefits of membership:

1. Assurance of a high ethical standing for you in the community, the state and the nation, before the public, the law, and the profession.
2. Lectures and postgraduate courses to keep you in touch with medical progress and to improve professional ability.
3. Your common interests safeguarded through the vigilant work of democratically selected officers who are (a) men of your own kind; (b) who know your problems and those of your patients; (c) who serve generously without compensation; (d) who need and ask for your coöperation and advice.
4. Benefits accruing from the action of numerous committees constantly working to advance your interests as a physician in your community; machinery solving problems of preventive and curative medicine which could not be worked out by you as an individual, even with a great sacrifice of time and effort.
5. Maintenance and constant improvement of standards of medical practice for the protection of patients.
6. A monthly Journal of high quality with the latest scientific literature, and general information important to you.

## EXECUTIVE COMMITTEE OF THE COUNCIL

February 9, 1938

### HIGHLIGHTS:

1. HOLC Socialized Medicine Scheme Denounced.
2. Serious problems of Afflicted Child Law administration studied and referred for action, in coöperation with the Crippled Children Commission and the Auditor General of Michigan.
3. Provision of necessary medical care to recipients of old-age benefits and to WPA families urged.
4. Medical-press relations program of the Kent County Medical Society (Grand Rapids) surveyed.
5. Plan of releasing medical-radio scripts approved.
6. Woman's Auxiliary three-way program outlined.

1. *Roll Call*.—The meeting was called to order by Chairman P. R. Urmston at 1:10 p. m. in the Pantlind Hotel, Grand Rapids. Those present were: Drs. Urmston, H. R. Carstens, A. S. Brunk, V. M. Moore, I. W. Greene. Also Drs. Henry Cook, L. Fernald Foster, Henry A. Luce, Wm. A. Hyland, H. S. Collisi, Frank E. Reeder and Executive Secretary Wm. J. Burns. Absent: Dr. P. A. Riley.

2. *Minutes*.—The minutes of the meeting of The Council, January 12-13, 1938, were approved as read.

3. *Financial Report*.—The financial report for January, 1938, was presented. Also the bills payable for the month. Motion of Drs. Carstens-Brunk that the report be accepted and placed on file and that the bills payable be paid. Carried unanimously.

4. *Afflicted-Crippled Child*.—(a) The request of the Crippled Children Commission that a technical advisory committee of consultants in burn cases be appointed was discussed. Motion of Drs. Greene-Moore that a preliminary list for this advisory committee be designated to the Commission. Carried unanimously.

(b) X-ray Fee. All phases of this matter were discussed and referred to the Contact Committee to Governmental Agencies, to present to the CCC and the Auditor General.

(c) Anesthesia. This was discussed and referred to the Contact Committee.

(d) Special Nurses. Recommendation was made by the Auditor General's office that special nurses be allowed in afflicted-crippled child cases, with a limit of ten days.

(e) The words "clinic" and "clinical" in the Afflicted-Child Law, and their interpretation by the Commission and by the Attorney General were discussed, and referred to the Contact Committee to governmental agencies.

(f) Fee for *examining* afflicted children was discussed, and referred for investigation, and subsequently to be presented to the Commission by the Contact Committee.

(g) Section 3 of the Afflicted-Child Act which reads that the superintendent shall designate the clinic "except where such child is in the care of a private physician or surgeon," was discussed with Drs. Schermerhorn, Dixon and Pyle. Referred to the Contact Committee.

(h) Osteomyelitis Consultants.—Referred to the Contact Committee to discuss with the Crippled Children Commission.

(i) More Refresher Courses.—Referred to the Contact Committee.

(j) Physicians Billed through the Hospitals.—Attention was invited to the law, whereby

physicians' bills must be sent through the hospital. This is to be inserted in the Secretary's Letter.

(k) The Chair asked if the filter system is of any help. Mr. Hill of the Attorney General's office stated emphatically yes. The Chair felt that the system should be made official, in order to make it permanent.

All these matters, including the request of the Commission for advice re fees on 26 new items for possible insertion in the fee schedule, were thoroughly studied and referred to the Contact Committee for action.

5. *Advisory Committee to Woman's Auxiliary*.—Dr. H. S. Collisi reported for his committee. (a) Is there a need for a Benevolent Fund? This was discussed and on motion of Drs. Brunk-Greene was referred back to the Advisory Committee for further study as to the need, with the request that the committee report at a later date to the Executive Committee. Carried unanimously. The Advisory Committee may place the question in the Secretary's Letter, asking the membership as to the need.

(b) The Auxiliary Committee is urging the organization of auxiliaries in every county where feasible and where possible.

(c) The Auxiliary Committee is urging the women to take advantage of membership in all clubs and societies to explain the background and good health work of the medical profession.

The matter of the Woman's Auxiliary program at the annual meeting was discussed. The Executive Committee felt that this program should be submitted to the Advisory Committee to Woman's Auxiliary, which in turn would submit it to the Committee on Scientific Work of the M.S.M.S.

6. *Social Workers*.—President Cook reported on meeting with representatives of social agencies in Detroit on January 26. He recommended the printing from time to time of articles in THE JOURNAL regarding the good work of social agencies, inasmuch as the medical profession and the social workers are all driving towards the same end-result. Motion of Drs. Carstens-Greene that Dr. Cook be thanked for this initial work, and that he be requested to arrange for the preparation of articles for publication in THE JOURNAL on the progressive activities of the social agencies. Carried unanimously.

President Cook spoke of the meeting of the Northwest Medical Conference in Chicago on Sunday, February 13, and the Indiana Secretaries' Conference in Chicago on February 12 (the two secretaries of the M.S.M.S. are on these



## EXECUTIVE COMMITTEE OF COUNCIL

programs). Motion of Drs. Greene-Carstens that the president be authorized to attend these meetings in Chicago, and bring back a report to the Executive Committee. Carried unanimously.

7. *Journal Subscriptions for Retired Members.*—This subscription fee was set at \$1.50 for Retired Members, on motion of Drs. Greene-Carstens. Carried unanimously.

8. *Survey of Committee on Distribution of Medical Care.* This was presented. In addition, the provision of necessary medical care to old age pensioners and the families of WPA workers was discussed, and action urged.

9. *Secretaries' Conference.*—(a) Secretary Foster gave a report on the Secretaries' Conference held in Lansing on January 23, which was accepted and placed on file.

(b) A report on the Press Relations Program of the Kent County Medical Society was given by Dr. Moore and Mr. Burns.

(c) Dr. Foster presented the report of the Public Relations Committee meeting of January 22. The following action of the PRC was approved, on motion of Drs. Carstens-Brunk, and carried unanimously: "Any talks given over the radio under the sponsorship of the M.S.M.S. and the talks given under the sponsorship of the Joint Committee on Health Education on the subjects of Mental Hygiene, Maternal Health, Cancer or Preventive Medicine, shall be approved by the chairmen of these committees. All other talks must be approved by the representatives of the M.S.M.S. to the Joint Committee."

(d) The monthly report of the Medico-Legal Committee was presented, accepted and placed on file.

(e) The meeting with the State Health Commissioner held in Ann Arbor on February 4 was reported by Secretary Foster, discussed, accepted and placed on file.

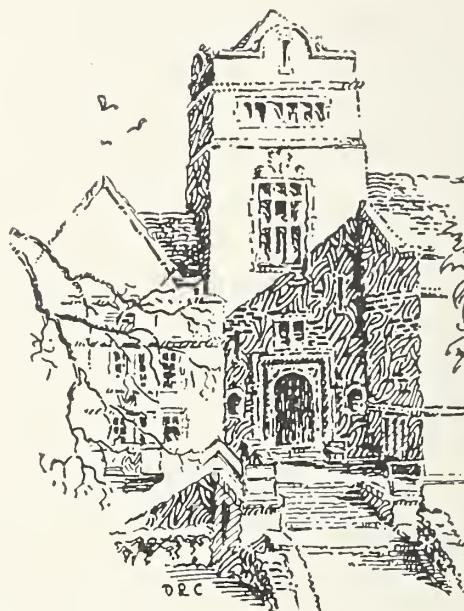
10. *HOLC Collective Medicine Plan.*—Dr. Luce outlined this activity in Washington, D. C., and

recommended that a letter be sent to the Michigan senators and congressmen in Washington urging them to protest against this socialized medicine. Motion of Drs. Greene-Brunk that the letter as drafted be approved and sent by the M.S.M.S. to the Michigan senators and representatives in Congress, with a copy to the A.M.A. Carried unanimously.

11. (a) *Center for Continuation Studies.*—This project was suggested by the Executive Secretary, who was authorized to continue activities in behalf of same.

(b) *Status of Healers.*—An inquiry concerning the status of a healing group was referred to the Executive Secretary to develop a legal brief.

12. *Adjournment.*—The meeting was adjourned at 6:25 p. m.



### MICHIGAN STATE MEDICAL SOCIETY PUBLIC RELATIONS COMMITTEE ASSIGNMENTS, 1938

L. F. FOSTER, M.D., CH., Bay City

To Huron-Sanilac

Lapeer

St. Clair

Gratiot-Isabella-Clare

Midland

Saginaw

Tuscola

Bay-Arenac-Iosco-Gladwin

F. T. ANDREWS, M.D., Kalamazoo

To Ottawa

Kent

Barry

Ionia-Montcalm

A. F. BLIESMER, M.D., St. Joseph

To Calhoun

Branch

St. Joseph

A. E. CATHERWOOD, M.D., Detroit

To Wayne

Oakland

Macomb

C. G. CLIPPERT, M.D., Grayling

To O.M.C.O.R.O.

Alpena-Alcona-Presque Isle

Northern Michigan:

(Cheboygan, Emmet, Charlevoix, Antrim)

Wexford:

(Wexford-Missaukee-Kalkaska)

C. D. HART, M.D., Newberry

To All societies in the Upper Peninsula

DEAN W. HART, M.D., St. Johns

To Eaton

Ingham

Hillsdale

Jackson

Clinton

Shiawassee

L. E. HOLLY, M.D., Muskegon

To Grand Traverse-Leelanau-Benzie

Manistee

Mason

Oceana

Muskegon

Newaygo

Mecosta-Osceola-Lake

F. B. MINER, M.D., Flint

To Genesee

Washtenaw

Lenawee

Monroe

Livingston

H. L. MORRIS, M.D., Detroit

To Wayne

A. V. WENGER, M.D., Grand Rapids

To Allegan

Kalamazoo-Van Buren

Berrien

Cass

COUNCIL AND COMMITTEE MEETINGS

1. *Sunday, February 27, 1938.*—Legislative Committee, Hotel Olds, Lansing, 4:00 p. m.
2. *Wednesday, March 2, 1938.*—Contact Committee with Crippled Children Commission and Auditor General, Hotel Olds, Lansing, 2:00 p. m.
3. *Wednesday, March 2, 1938.*—Contact Committee with State Health Commissioner Don W. Gudakunst, Hotel Olds, Lansing, 7:00 p. m.
4. *Saturday, March 12, 1938.*—Cancer Committee, Detroit Athletic Club, Detroit, 6:30 p. m.
5. *Sunday, March 13, 1938.*—Executive Committee of The Council, Hotel Statler, Detroit, 3:00 p. m.
6. *Wednesday, March 16, 1938.*—Liaison Committee with Hospital Association, W. C. M. S. Building, Detroit, 4:00 p. m.
7. *Wednesday, March 23, 1938.*—Public Relations Committee, M. S. C. Union Bldg., E. Lansing, 3:00 p. m.
8. *Sunday, March 27, 1938.*—Committee on Scientific Work, Hotel Olds, Lansing, 4:00 p. m.
9. *Wednesday, March 30, 1938.*—Legislative Committee, Durant Hotel, Flint, 4:00 p. m.

COMMUNICATIONS

STATE OF MICHIGAN  
EXECUTIVE OFFICE  
LANSING

March 16, 1938.

Dear Doctor Cook:

Fully realizing that many persons in this State are insufficiently supplied with medical care because of their inability to pay for such services, I am anxious to provide every reasonable means of assistance. To that end, I have asked the Welfare and Health Departments to select a list of names to constitute a committee to study ways and means of meeting the medical needs of welfare clients, old age assistance recipients and WPA workers. I sincerely hope this committee can work with and be of service to the Michigan State Medical Society and its committees studying the same problem, in accordance with the recently announced American Medical Association plan.

It is to be hoped that out of such a joint study will come recommendations that will allow for the practicing physicians of this State rendering more and better service to their medically indigent patients. It is further hoped that this will allow eventually for the development of a sound working program based upon the fundamental American principles of practice of medicine, furthering the individual patient-physician relationship. Nothing in our public health or welfare programs should tend to lead away from this. It is only through complete coöperation of government and organized medicine that this very difficult and real problem can be solved.

I appreciate greatly the help your Society has already given Dr. Gudakunst and will welcome any further suggestions as to the scope of the study and personnel of the committee.

Sincerely,  
FRANK MURPHY, *Governor.*

Dr. Henry Cook, President  
Michigan State Medical Society,  
Flint, Michigan.

OPEN LETTER TO EVERY DOCTOR,  
M.S.M.S.

Dear Doctor:

The date to which you have been looking forward is *April 27, 1938*—Place—*Herman Kiefer Hospital*—Hours—*10 to 12*.

You have been hungering for good sound practical help in your treatment of the mentally ill. The Department of Health of the City of Detroit recognized your needs when it secured two speakers, Dr. W. S. Sadler of Chicago and Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C. Speakers with practical insight into the subject. Speakers who will help you.

The Department of Health of Detroit extends a cordial invitation to all members of the Michigan State Medical Society to attend this portion of the program as well as all other programs.

The Mental Hygiene Committee of the Michigan State Medical Society actually insists on your attendance, April 27. We'll be seeing you.

Cordially yours,  
Committee on Mental Hygiene,  
Michigan State Medical Society.

Cardiovascular Syphilis: Clinical Lecture at  
Atlantic City Session

JAMES E. PAULLIN, Atlanta, Ga. (*Journal A. M. A.*, Oct. 2, 1937), claims that involvement of the cardiovascular system accounts for a large group of persons who suffer the most disabling effects of latent syphilis. Syphilitic aortitis, from the standpoint of the pathologist, is a disease recognized far more frequently at necropsy than in the clinic. Its incidence in different parts of the country varies with the character of the population. Since syphilitic infection is far more prevalent in Negroes than in other races and since it occurs more frequently among the ignorant and the indigent, it naturally follows that aortitis is most commonly found in these groups. From statistical data collected by Turner it would seem that approximately 10 per cent of all patients with latent syphilis will have demonstrable clinical evidence of cardiovascular involvement. In a series of 6,253 cases of syphilis in a late stage collected by the Coöperative Clinical Group, approximately 619 or 10 per cent, of the patients had cardiovascular syphilis on admission or acquired it later. The wonder is that a far greater number did not give clinical manifestations. Warthin and his associates have observed at autopsy that the aorta is involved, either macroscopically or microscopically, in approximately 90 per cent of persons with latent syphilis. The age group most frequently affected is that between 30 and 55 years, although cases may occur earlier and some even later. Every person who has syphilis is an excellent candidate for cardiovascular involvement. If every person who acquires syphilis could receive the benefits of adequate treatment, such as has been outlined by the Coöperative Clinical Group, there would be few patients with cardiovascular manifestations of latent syphilis. A patient with cardiovascular syphilis should be subjected to the usual forms of treatment that are prescribed for any patient with heart disease. As to specific treatment, patients may be divided into two groups, those who have a normally functioning myocardium and those who have congestive heart failure. If the patient when first seen has cardiovascular syphilis and congestive heart failure, antisiphilitic treatment must be undertaken with the greatest care. Potassium iodide is given by mouth as soon as possible, and smaller doses of the heavy metals at weekly intervals.



## COUNTY SOCIETIES

### CALHOUN COUNTY

WILFRID HAUGHEY, M.D.  
*Secretary*

The February meeting of the Calhoun County Medical Society was called to order February 1 after dinner at the Sky Club. An innovation in our meeting was singing during and after dessert with several solos by Dr. E. Van Camp.

Dr. Udo J. Wile, Professor of Dermatology, University of Michigan, was introduced by Dr. C. E. Hills, who once was on Dr. Wile's service in Ann Arbor.

Dr. Wile spoke of "Syphilis as a Surgical Risk." He discussed his subject under these headings: 1. The syphilitic with a surgical condition. 2. The syphilitic with surgical syphilis. 3. The syphilitic with surgical mimicry.

Drs. Kolvoord, Harris, Mustard, Rosenfeld and Holes asked questions which Dr. Wile answered graciously and at length.

Dr. Kenneth Lowe then introduced Professor William V. O'Connell, Department of English and Speech, Battle Creek College, who gave us several readings by Kipling and others, also three from George McKay.

The Secretary offered the names of Dr. Hugh Robins of Marshall, and Dr. James D. Sleight of Battle Creek, for election, this was second reading. Upon motions of Drs. Slagle and Wenke, they were elected to membership.

The Secretary read the report of the Cancer Committee, which was accepted and adopted, except the suggestion of having one of our regular meetings a public meeting.

Dr. Cooper read a report of the Maternal Health Committee and outlined the plan of the County Health Unit in child care during the first year of life.

By motion of Drs. H. M. Lowe and Hale, the report and plan were accepted and approved.

Dr. C. G. Wencke, for the Necrology Committee, offered resolutions of sympathy to the family of Dr. Steinbach, who died January 17, 1938. Approved and resolution ordered transmitted.

Dr. Stanley Lowe reported a credit plan whereby our members may have credit information on persons asking credit. There are now 25 doctors and 20 dentists signed up. The report was accepted. Our members will be interviewed individually.

The Secretary called attention to two questionnaires from the State Society, one for the Program Committee and one for the Committee on Medical Care. Members are asked to fill these out.

### EATON COUNTY

THOMAS WILENSKY, M.D.  
*Secretary*

The regular monthly meeting of the Eaton County Medical Society was held at the Carnes Tavern, Charlotte, on the evening of Thursday, February 17. This meeting was planned as Eaton County's "State Society Night" in miniature and a goodly attendance braved the inclement weather to hear Dr. Dean W. Hart, of St. Johns, representing the Public Relations Committee of the M.S.M.S. in Eaton County, and William J. Burns, LL.B., Executive Secretary of the Michigan State Medical Society.

The Ladies of the Auxiliary to the Eaton County Medical Society, who had been invited to listen to the speaker of the evening, trooped in after dinner and were welcomed in gallant style by Vice President Bert VanArk.

Dr. VanArk introduced Public Relations Committeeman Hart who spoke briefly and to the point on various matters of great interest and significance, viz., THE JOURNAL, the active Ethics Committee of the M.S.M.S., prosecution of violators of the Medical Practice Act, Preventive Medicine, Speakers Bureau of the M.S.M.S. and the State meeting to be held in Detroit in September.

The state society's zealous and able secretary, Bill Burns, was then introduced in true Master of Ceremonies style by Dr. VanArk. Mr. Burns' talk, "What's Going On," concerned itself primarily with a discussion of the distribution of medical care and the far-reaching changes which have of recent years been making unusual demands of the medical profession.

The speaker explained in detail the why-for of the A.M.A.'s request that the county medical societies in the U.S.A. (2,054 of them) conduct medical surveys in their counties, so that the distribution of medical service may be more accurately estimated.

Mr. Burns spoke of other matters of outstanding interest to the physician and at the conclusion of his talk was accorded a most enthusiastic vote of thanks.

At the business meeting which followed, Dr. VanArk instructed the Public Relations Committee of the Eaton County Medical Society to commence functioning in the interests of a medical survey of Eaton County.

### GENESEE COUNTY

C. W. COLWELL, M.D.  
*Secretary*

Minutes of the meeting of the Genesee County Medical Society held at the Dresden Hotel on February 16 at 12 o'clock noon.

Following the luncheon the meeting was called to order by the president, Dr. McArthur. The minutes of the last meeting were read and approved. Several communications were then read by the secretary. This being a purely scientific meeting, no business was transacted.

The guest speaker for this meeting was Dr. Norman Clark of Detroit, who spoke on "Thyroid Surgery in Cardiac Cases."

This subject was discussed in detail by many members of the Society. Meeting then adjourned.

### HILLSDALE COUNTY

E. G. MCGAVRAN, M.D.  
*Secretary*

The February meeting of the Hillsdale County Medical Society was held at the Keefer Hotel at 6:30 p. m., February 17, 1938.

The president, Dr. W. E. Alleger, called the meeting to order and the speaker of the evening, Dr. W. G. Maddock of Ann Arbor, was introduced by Dr. L. W. Day.

Dr. Maddock dealt with the subject of the emergency treatment of the victims of automobile accidents at the site of the accident. His remarks were of a very practical and helpful nature and he was assisted in his demonstration of the emergency application of splints and fixed traction by Dr. Bartlett of Ann Arbor.

The ambulance drivers of the county were guests of the Society at this meeting as it is hoped that

## COUNTY SOCIETIES

their ambulances will soon be equipped with approved emergency equipment so that they may serve in the best possible way the needs of the community.

Following a short recess, a business meeting was held at which reports of the program, x-ray, post-graduate and maternity committees were presented. The proposed constitution for the Society was presented and will come up before the next meeting for discussion as by that time each member of the society will have received a copy for study.

### INGHAM COUNTY

R. J. HIMMELBERGER, M.D.

*Secretary*

The February meeting of the Ingham County Medical Society was held February 15, 1938, at the Hotel Olds, Lansing. There were eighty-eight members and seven guests present.

The meeting was called to order by the president, Dr. Dana Snell.

The secretary read the applications of Dr. A. V. Smith of Mason and Dr. W. D. Albert of Leslie, for associate membership. Both were elected to associate membership by an unanimous ballot.

The secretary read an invitation from the Medical Auxiliary to attend their next meeting at which Dr. L. M. Snyder will talk on "Modern Police Methods."

A letter was read from the American Legion asking for coöperation in examining boys at the Wolverine Boys' State Camp in June. This was referred to the Public Health Committee.

Several announcements from the State Society were read, among which was one stating that blanks are provided by the M.S.M.S. for reporting violations of the Medical Practice Act.

Dr. Wellman of the Program Committee reported that Dr. Furstenberg would speak at the March meeting and that the Clinic Program is about completed.

Dr. Shaw of the Finance Committee reported on the Budget for the year 1938.

Dr. Snell introduced Drs. Clark and J. E. Barrett as new members of the Society. He also introduced the United States Public Health Service personnel who are here working on the Venereal Disease Survey.

There being no further business, Dr. Snell introduced the speaker of the evening, Dr. Lawrence Reynolds, of Detroit, who spoke on "Dyspepsia."

### JACKSON COUNTY

HORACE WRAY PORTER, M.D.

*Secretary*

The January meeting was called to order by President John Van Schoick on January 7, 1938. Numerous announcements from the State Society were made by the secretary.

The name of Dr. Grant Otis, associate of Dr. A. M. Schaeffer, was presented to the general membership and was approved unanimously for membership.

The following amendment to the By-laws of the Jackson County Medical Society was passed:

"Effective on this date, December 14, 1937, any member of the Jackson County Medical Society who shall contract, or apply for a contract involving medical and/or surgical services, with any political or other group handling the expenditure of public monies granted for philanthropic purposes, without the knowledge and sanction of the Board of Directors of said Society shall be considered to have violated the code of medical ethics."

### KALAMAZOO-VAN BUREN COUNTIES

LOUIS W. GERSTNER, M.D.

*Secretary*

The annual meeting of the Kalamazoo Academy of Medicine was called to order in the Academy rooms on December 21, 1937, by President Wm. G. Hobeke. Following numerous miscellaneous business, Dr. Ralph J. Hubbell was unanimously elected president for the coming year. Others were elected as follows:

First Vice President—Dr. Joseph Gilding, Vicksburg.

Second Vice President—Dr. C. A. Alexander, Kalamazoo.

Third Vice President—Dr. F. M. Boothby, Lawrence.

Treasurer—Dr. Robert J. Armstrong, Kalamazoo.

Librarian—Dr. L. H. Stewart, Kalamazoo.

Member Board of Censors—Dr. Hazel Prentice, Kalamazoo.

Member Board of Censors—Dr. John R. MacGregor, Kalamazoo.

Delegate—Dr. Fred M. Doyle, Kalamazoo.

Alternate Delegate—Dr. I. W. Brown, Kalamazoo.

Alternate Delegate—Dr. Burt Diephus, South Haven.

The February meeting of the Kalamazoo Academy of Medicine was held in the Academy rooms the evening of February 15, 1938. President Dr. R. J. Hubbell presided.

Following the new order of business, Dr. Bruce H. Douglas of Herman Kiefer Hospital, Detroit, discussed the diagnosis, case histories and treatment of tuberculosis. The business session of the Academy followed this address.

The newly appointed committee of preventive medicine, consisting of Dr. Collins, chairman, Drs. Bodmer, Dowd and Doyle, presented its report.

The report was discussed by Drs. Doyle, Crum, MacGregor and S. E. Andrews. Dr. Crum moved that we accept the written report. Seconded by Dr. Fast. Motion lost.

Dr. Crum reported for the Crane Memorial Committee.

Dr. Bennett moved that the Academy give this Committee power to publish a volume of Dr. Crane's work. Supported by Dr. Gregg and carried.

### LENAWEE COUNTY

ESLI T. MORDEN, M.D.

*Secretary*

"State Society Night" was celebrated by the Lenawee County Medical Society on February 16, 1938, at the Lenawee Hotel, Adrian. State Society officers present were Drs. L. Fernald Foster, Secretary of the Michigan State Medical Society; Dr. F. B. Miner, member of the M.S.M.S. Public Relations Committee; Dr. Howard H. Cummings, Councilor for the 14th District, and Executive Secretary Wm. J. Burns. Also present were Probate Judge E. R. Aman and County ERA Administrator McVay.

Members of the Lenawee County Medical Society present were as follows:

Drs. I. J. Beebe, J. P. Bland, C. W. Case, G. M. Clafflin, W. T. Claxton, W. E. Colbath, G. C. Hall, H. H. Hammel, H. H. Heffron, R. F. Helzerman, W. B. Hornsby, F. A. Howland, G. H. Lamley, C. S. Lane, W. S. Mackenzie, R. G. B. Marsh, F. J. McCue, E. T. Morden, B. Patmos, W. L. Peters, E. C. Raabe, L. J. Stafford, C. A. Van Dusen, O. Whitney, and A. C. Wood.

### MONROE COUNTY

FLORENCE AMES, M.D.

*Secretary*

We members of the Monroe County Medical Society had a very great pleasure at our meeting



of January 20, 1938. Our district Councilor, Dr. Howard H. Cummings of Ann Arbor, visited us. He brought us greetings from the Council, told us of the work of the various committees, of the devotion of the committee-members, and of the projects of the State Society. He made all our chests (we hope not our heads) swell with pride at being members of the organization.

Then he gave us a splendid discussion of the subject "Toxemias of Pregnancy."

One announcement of Doctor Cummings brought joy to us all, namely—that the Council of the Michigan State Medical Society has decided to make Ann Arbor a center for postgraduate courses. No doctor in the county will have to go more than fifty miles to study and most of them considerably less.

### MUSKEGON COUNTY

L. E. HOLLY, M.D.

*Secretary*

The regular meeting of the Muskegon County Medical Society was held at the Occidental Hotel, Friday, January 21, 1938, 6:30 P. M.

The meeting was called to order at 8:00 P. M. by President Teifer. Dr. George LeFevre introduced Mr. Fred Whitlock, the guest of Dr. Colignon. Dr. Dolfin introduced his guest, Dr. Kemink. Physicians from out of town were Dr. Wenger of Coopersville and Dr. Thompsett of Hesperia.

Following the introduction of the guests, the President introduced our two new members, Drs. Lange and Sholle.

The first speaker of the evening, Dr. Harry A. Towsley, was introduced by Dr. P. S. Bradshaw.

The second speaker, Dr. John J. Englefried, was introduced by Dr. Bradshaw.

Following the discussion of these two papers, a short business session was held. The President appointed Dr. Diskin to substitute for Dr. Swartout on the Filter Committee.

Dr. Teifer emphasized that in cases of indigents applying for marriage licenses (they will do that), a very minimum charge or no charge at all should be made.

The application of transfer of Dr. A. Anderson from Berrien County to Muskegon County was accepted.

Article VIII of the Constitution was approved.

### OTTAWA COUNTY

D. C. BLOEMENDAAL, M.D.

*Secretary*

The March meeting of the Ottawa County Medical Society was held Tuesday, March 8, 1938, at the Warm Friend Tavern, Holland. Twenty members were present. Dr. G. J. Kemme, president of the Society, announced the appointment of the following committees:

*Public Relations Committee.*—Dr. R. H. Nichols, Chairman, Dr. S. L. DeWitt, Dr. E. Vonder Berb.

*Maternal Health Committee.*—Dr. Wm. Westrate, Chairman, Dr. Cornelius E. Boone, Dr. Iva M. Lickly.

Dr. Kenneth L. Burt, Chief Pathologist for the Michigan State Sanitarium at Howell, was the guest speaker. Doctor Burt discussed tuberculosis and its treatment. Several interesting x-ray films were exhibited showing the various stages of pulmonary tuberculosis and other pulmonary conditions such as extra pleural pneumothorax, paraffin injections, lung abscess, pneumonitis, and atypical bronchopneumonia.

### TUSCOLA COUNTY

R. R. HOWLETT, M.D.

*Secretary*

The Tuscola County Medical Society held a joint meeting with the Woman's Auxiliary on March 11, 1938, at Murray Hall, Wahjamega. Dr. L. Fernald Foster, Secretary of the Michigan State Medical Society, presented the objectives of the A.M.A. and the State Society in their surveys of medical need and distribution of medical care. A general round table discussion followed.

Dr. P. R. Urmston, Chairman of the M.S.M.S. Council, spoke briefly on other activities of the State Society.

The State Society's survey blanks were filled out by the attending members—each question being discussed as encountered.

The application for membership of Dr. R. L. Dixon, genial Superintendent of the Michigan Farm Colony at Wahjamega, received its final reading, was voted upon and accepted.

Dr. B. H. Starmann discussed some variations and difficulties being encountered in fees for prenuptial examinations and made a plea for more uniform fees.

Drs. E. H. Merrill, J. A. Vatz and T. E. Hoffman were appointed to the Committee on Maternal Health.

### WASHTENAW COUNTY

WM. M. BRACE, M.D.

*Secretary*

The February 8 meeting of the Washtenaw County Medical Society was a joint session with the members of the Ann Arbor Lawyers' Club and the Washtenaw Bar Association held at the Michigan Union.

The meeting was called to order by President-elect Dr. John W. Kemper, who welcomed the lawyers. Greetings from President S. L. LaFever were read.

Mr. Carl H. Stuhlerberg spoke on behalf of the legal organizations. Dr. Kemper called on Dr. H. H. Cummings who introduced the speaker, Mr. Wm. J. Burns, Executive Secretary of the Michigan State Medical Society.

Mr. Burns spoke of the aims of the State Society which are carried on in two ways—education and service. Education must be given to the postgraduate and undergraduate, as well as to the public. Adequate service must be provided for the non-indigent and indigent by the medical profession.

Various health protection laws recently passed by the Michigan Legislature were discussed by Mr. Burns. The reason for the passage of the state narcotic license law was also explained.

Discussants were Mr. Rapp, Drs. Donaldson, Belote and Weller.

It costs a lot to live these days,  
More than it did of yore,  
But, when you come to think of it,  
Isn't it worth a whole lot more?

All workers are of two classes—those who do their best work today and forget about it; and those who promise to do their best work tomorrow—and forget about it.

## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### Calhoun County

The February and March meetings of the Woman's Auxiliary were all-day "sewing bees" for the hospitals. The first Tuesday in February, members of the auxiliary met at the Nurses Lodge of Leila Hospital and sewed all day with the exception of an hour or so taken for a coöperative luncheon and brief business meeting at noon.

Likewise, the first Tuesday in March was spent at the Nurses Lodge of Nichols Hospital. The past presidents were chosen as chairmen to plan a benefit bridge party to be given at the Community Hospital in the near future for the purpose of raising funds to purchase furnishings for one room in the new Community Hospital.

DOROTHY G. LOWE,  
*Press Chairman.*

### Eaton County

The Eaton County Auxiliary met on February 17. After the dinner a brief business meeting was held. Plans for assembling layettes for distribution throughout the County by the Kellogg Foundation were discussed. Later in the evening the ladies were guests of the doctors to hear Mr. William Burns, Executive Secretary of the State Medical Society.

MRS. B. P. BROWN,  
*Press Chairman.*

### Ingham County

The evening of Washington's Birthday found the members of the Auxiliary and their husbands at the Women's clubhouse eager to hear Dr. LeMoynes Snyder talk on scientific crime detection.

An additional pleasant surprise was the introduction of Alvin Neller, who led several numbers of group singing accompanied by Mrs. Jane Davey at the piano. Mrs. P. T. VanderZalm, President of the Auxiliary, then introduced our speaker, who described modern police methods in a very entertaining and instructive manner, assisted by Lieutenant Milbar of the Michigan State police. We were allowed to share in a demonstration of some special equipment with lie detection.

Following the discussion and demonstration delicious refreshments were served, buffet style from a table made attractive with gleaming silver coffee service and centered with a bowl of red roses. Mrs. Loree, general chairman of the social committee for the year, was assisted by Mrs. Hart, Mrs. McNamara, Mrs. Huntley and Dr. Edith Hall-Kent.

MRS. P. C. STRAUSS,  
*Chairman of Publicity Committee.*

### Jackson County

The Women's Auxiliary met at the home of Mrs. George Seybold, Tuesday evening, February 15. A six-thirty dinner was served to the members by a committee composed of Mesdames E. C. Corley and Harold Dold; co-chairmen R. H. Alter, J. O'Meara, Charles Dengler, W. B. Anderson and E. S. Peterson.

The president, Mrs. John Ludwick, conducted a short business meeting. At this time the report was made that the project of painting the children's ward at the Foote Hospital was assured.

Mrs. Horace Porter was program chairman for the evening. Mrs. Lawrence Hess was the speaker. She stressed to the Auxiliary members their re-

sponsibility to the community to publicize the advancements continually being made through science. Mrs. Hess said that the doctor's wife occupied a strategic position between the laity and profession and could do an excellent community service in promoting an intelligent scientific outlook on health problems to replace the old emotional approach. Her talk was followed by a very animated discussion of her subject.

MRS. ARTHUR M. SHAEFFER,  
*Press Chairman.*

### Kalamazoo County

Twenty-eight members enjoyed the coöperative dinner and meeting of the Woman's Auxiliary at the home of Mrs. R. A. Morter on February 15, 1938. Spring flowers made the various rooms most attractive.

At the business meeting the resignation of Mrs. R. W. Shook as Secretary was read and Mrs. L. J. Crum was appointed to act in that position for the remainder of the year. Mrs. Boys announced the names of five ladies who are now eligible for membership.

On informal evening followed, with bridge, sewing, and knitting as diversions.

(MRS. HUGO) BARBARA K. AACH,  
*Publicity Chairman.*

### Monroe County

The Woman's Auxiliary entertained their husbands at a dinner-bingo party on February 18. This social evening took the place of the regular Auxiliary Meeting.

Eleven couples enjoyed a hilarious evening of bingo, the prizes being big items of surprise. Each person attending contributed a mysterious package which was in turn played for.

For our March meeting we are joining the Medical Society in sponsoring a public lecture, Fads and Quackery in Medicine, by Dr. Warren W. Babcock.

(MRS. VINCENT) MARTHA BARKER,  
*Press Chairman.*

### Saginaw County

Forty members of the Saginaw County Medical Auxiliary were delightfully entertained at the home of the president, Mrs. L. C. Harvie, Ardussi Drive, on Friday, February 18. A dessert luncheon was enjoyed, after which a brief business meeting was held. At this time, plans were formulated to secure a speaker on some health topic for the annual Public Relations dinner meeting in April, which is sponsored by the Parent-Teachers Association. It was also decided to compliment the members of Bay County Medical Auxiliary with a luncheon on March 25, at which time Miss Mary O'Reilly will review current books.

Following the meeting, a book review on A. J. Cronin's "Citadel" was given in splendid fashion by one of the members, Mrs. Gunther Tiedke.

Contract bridge was played, prizes going to Mrs. W. B. Clark and Mrs. Arthur Leitch. House prize was awarded to Mrs. G. Harry Ferguson.

Mrs. Harvie was assisted by Mesdames Frank Novy, Victor Hill, Gunther Tiedke, and Dale Thomas.

(MRS. ARTHUR E.) LOUISE LEITCH,  
*Press Chairman.*



# M. S. M. S. JOURNAL ADVERTISERS W OF THE MICHIGA

**ALUMNI ASSOCIATION, WAYNE UNIVERSITY MEDICAL SCHOOL,** Detroit. Advertiser in 1937, continuing in 1938.

**AMERICAN CAN COMPANY,** New York City. M.S.M.S. Journal advertiser of many years' standing, continuing in 1938.

*Advertising Agent: Fuller, Smith & Ross, New York.*

**AMERICAN EXPRESS COMPANY,** New York City. A new M:S.M.S. Journal advertiser in 1938.

**ARLINGTON CHEMICAL COMPANY,** Yonkers, N. Y. Journal advertiser in 1937, carrying a message in this number.

*Advertising Agent: Noyes & Sproul, New York City.*

**BILHUBER-KNOLL CORPORATION,** Jersey City, N. J. Journal advertiser in 1937, continuing in 1938.

**S. H. CAMP COMPANY,** Jackson, Michigan. Journal advertiser of many years' standing continuing in 1938.

*Advertising Agent: Lawrence Fertig & Company, New York City.*

**CENTRAL LABORATORY,** Saginaw, Michigan. Journal advertiser of many years' standing continuing in 1938.

**CHICAGO TUMOR INSTITUTE,** Chicago, Illinois. A new Journal advertiser in 1938.

**CHESTERFIELD CIGARETTES,** New York City. Journal advertiser of many years' standing continuing in 1938.

*Advertising Agent: Newell-Emmett Company, New York City.*

**COCA-COLA COMPANY,** Atlanta, Georgia. Long time M.S.M.S. Journal advertiser continuing in 1938.

**COOK COUNTY GRADUATE SCHOOL OF MEDICINE,** Chicago, Illinois. Long time M.S.M.S. Journal advertiser continuing in 1938.

**CORN PRODUCTS SALES COMPANY,** New York City. Journal advertiser of many years' standing continuing in 1938.

*Advertising Agent: E. W. Hellwig, New York City.*

**CURDOLAC FOOD COMPANY,** Waukesha, Wisconsin. Another M.S.M.S. Journal advertiser of many years' standing continuing in 1938.

**R. B. DAVIS COMPANY,** Hoboken, N. J. Advertiser of many years' standing continuing in The Journal in 1938.

*Advertising Agent: J. M. Mathes, Inc., New York, City.*

**DeNIKE SANITARIUM,** Detroit, Michigan. Long time M.S.M.S. Journal advertiser continuing in 1938.

**FAIRCHILD BROTHERS & FOSTER,** New York City. Long time advertiser continuing in The M.S.M.S. Journal in 1938.

**FERGUSON-DROSTE-FERGUSON,** Grand Rapids, Michigan. Long time Journal advertiser continuing in 1938.

**GENERAL ELECTRIC X-RAY CORPORATION,** Chicago, Illinois. Journal advertiser of many years' standing continuing in 1938.

**HACK SHOE COMPANY,** Detroit. Journal advertiser of many years' standing continuing in 1938.

**J. F. HARTZ COMPANY,** Detroit. Long time advertiser in The Journal continuing in 1938.

*Advertising Agent: Holden, Graham & Clark, Inc., Detroit.*

**H. J. HEINZ COMPANY,** Pittsburgh, Pa. Journal advertiser of many years' standing continuing in 1938.

*Advertising Agent: Maxon, Inc., Detroit.*

**HYNSON, WESTCOTT & DUNNING, INC.,** Baltimore, Maryland. Journal advertiser of many years' standing continuing in 1938.

**INGA-KIT COMPANY,** Detroit, Michigan. A new Journal advertiser in 1938.

**G. A. INGRAM COMPANY,** Detroit, Michigan. Long time advertiser in The Journal continuing in 1938.

**KENILWORTH SANITARIUM,** Kenilworth, Illinois. For many years a Journal advertiser, continuing in 1938.

# ED NO INTRODUCTION TO MEMBERS

## TE MEDICAL SOCIETY

**LEDERLE LABORATORIES, INC.**, New York City. Long time advertiser in The Journal continuing in 1938.

**ELI LILLY & COMPANY**, Indianapolis, Indiana. Journal advertiser for many years continuing in 1938.

**MEAD JOHNSON & COMPANY**, Evansville, Indiana. Journal advertiser for many years continuing in 1938.

**MEDICAL PROTECTIVE COMPANY**, Wheaton, Illinois. Long time advertiser in The Journal continuing in 1938.

**MILWAUKEE SANITARIUM**, Wauwatosa, Wisconsin. Journal advertiser for many years continuing in 1938.

**NATIONAL DISCOUNT & AUDIT COMPANY**, New York City. The year 1938 marks the third consecutive year as a Journal advertiser.

**HOTEL OLDS**, Lansing, Michigan. Continuing in 1938 for the third consecutive year as a Journal advertiser.

**PARKE, DAVIS & COMPANY**, Detroit. Continuing in 1938 after many years as a M.S.M.S. Journal advertiser.

**PETROLAGAR LABORATORIES**, Chicago. Journal advertiser for many years continuing in 1938.

*Advertising Agent: John F. Murray Advertising Agency, New York City.*

**PHILIP MORRIS COMPANY**, New York City. Long time Journal advertiser continuing in 1938.

*Advertising Agent: The Biow Company, New York City.*

**PHYSICIANS CASUALTY ASSOCIATION**, Omaha, Nebraska. Journal advertiser continuing the third year in 1938.

**PLYMOUTH SANITARIUM**, Plymouth, Indiana. 1937 Journal advertiser continuing in 1938.

**MARY E. POGUE SCHOOL**, Wheaton, Illinois. Another Journal advertiser continuing the third year in 1938.

**PROFESSIONAL MANAGEMENT**, Battle Creek, Michigan. Continuing in 1938 for the third consecutive year in The Journal.

**RADIUM & RADON CORPORATION**, Chicago, Illinois. Continuing in 1938 for the third consecutive year in The Journal.

**RALSTON PURINA COMPANY**, St. Louis, Missouri. Continuing in 1938 for the third consecutive year in The Journal.

*Advertising Agent: Gardner Advertising Company, St. Louis, Mo.*

**ROGERS MEMORIAL SANITARIUM**, Oconomowoc, Wisconsin. Long time advertiser in The Journal continuing in 1938.

**RUPP & BOWMAN COMPANY**, Toledo, Ohio. Continuing in 1938 after many years of continuous advertising in The Journal.

**SAWYER SANITARIUM**, Marion, Ohio. Continuing in 1938 after many years of continuous advertising in The Journal.

**S.M.A. CORPORATION**, Cleveland, Ohio. Journal advertiser for several years continuing in 1938.

*Advertising Agent: Brothers Advertising Agency, Cleveland, Ohio.*

**SMITH, KLINE & FRENCH LABORATORIES**, Philadelphia, Pennsylvania. Journal advertiser of many years' standing continuing in 1938.

**E. R. SQUIBB & SONS**, New York City. Journal advertiser of many years' standing continuing in 1938.

**FREDERICK STEARNS & COMPANY**, Detroit. Journal advertiser of many years' standing continuing in 1938.

*Advertising Agent: Harry C. Phibbs Advertising Company, Chicago.*

**TREATMENT REGULATOR CORPORATION**, Detroit, Michigan. A new Journal advertiser in 1938.

**WAUKESHA SPRINGS SANITARIUM**, Waukesha, Wisconsin. Continuing in 1938 after many years as a Journal advertiser.

**ZEMMER COMPANY**, Pittsburgh, Pennsylvania. New Journal advertiser in 1938.

*Advertising Agent: Root-Mandabach Advertising Agency, Chicago.*



MICHIGAN'S DEPARTMENT  
OF HEALTH  
DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

### STATE COUNCIL OF HEALTH MEETS

The State Council of Health, official advisory council to the state health commissioner, held its first organization meeting of 1938 in Lansing, March 2, with Commissioner Don W. Gudakunst. Dr. U. G. Rickert of Ann Arbor was elected president of the council and Dr. Robert B. Harkness of Hastings becomes the new secretary. Other members of the council include Dr. George J. Curry, Flint; Dr. W. Lloyd Kemp, Birmingham; and Dr. H. Lee Simpson, Detroit.

Major activities of the council included the approval of the 1938 Rules and Regulations of the Michigan Department of Health for the Control of Communicable Diseases and the adoption of the qualification standards for health officers as approved by the 1935 Conference of State and Territorial Health Officers.

### Changes in Rules and Regulations

Regulations for the control of diphtheria have been modified to differentiate between the control of a case and of a carrier. The new definitions of a case and a carrier are as follows:

*"A case of diphtheria is a person whom the attending physician or the medical health officer believes to have clinical symptoms attributable to diphtheria or has had such within a period of five weeks."*

*"A diphtheria carrier is any person for whom a culture from throat or nose or other part of the body indicates the presence of the diphtheria bacilli and who does not and has not shown any clinical evidence of the disease for a period of five weeks. However, an individual who has been in quarantine as a case and continues to show positive laboratory cultures for a period longer than five weeks may, at the discretion of the health officer, be continued in quarantine as a case."*

The regulations provide that diphtheria cases shall be *quarantined* and shall be released only when two bacteriological examinations of secretions from the patient's throat and nose, made not less than twenty-four hours apart, show no diphtheria bacilli present.

Diphtheria carriers shall be *isolated*. Carriers may be released when, after examination in a registered laboratory, a virulence test shows the organisms to be non-virulent or when two successive cultures from throat and nose, taken at intervals of not less than twenty-four hours, have been found to contain no diphtheria bacilli.

Syphilis, gonorrhea and chancroid cases hereafter must be reported by name or initial. Reporting by number will no longer be permissible.

Changes in the regulations regarding scabies, impetigo and ringworm provide that such cases shall be excluded from school until recovery, except that cases may be readmitted to school by authority of the health officer provided that such cases are receiving medical treatment and are under daily observation of the health officer or his representative.

A minor clarification of the smallpox regulation provides that such "cases shall be quarantined until the skin lesions have become clear of all crusts, scabs or scales."

The new regulation regarding Vincent's infection gives the health officer discretion in excluding such cases from school. The former regulation provided for exclusion in all cases.

A new regulation provides that lay health officers in counties having no full-time health department shall secure the advice or consultation of a physician in all matters where a decision is necessarily based on a knowledge of medical science; the expense for such service is an obligation of the local board of health.

The revised rules and regulations will be printed and ready for distribution in April. Physicians may secure copies upon request to the Michigan Department of Health at Lansing.

### Qualifications of Health Officers

The standards of qualifications for medical health officers as established and recommended by the Conference of State and Territorial Health Officers will form the basis for the approval of such personnel in Michigan following the adoption of these recommendations by the State Council of Health. In order to obtain federal aid for local health departments, the personnel of such departments is required by the United States Public Health Service to comply with these standards.

The following standards in addition to acceptable personal traits will apply to medical officers qualifying for public health service in Michigan:

#### I. Basic educational requirements shall be:

- A. The degree of Doctor of Medicine from a reputable medical school and eligibility to examination for medical licensure in the state where service is to be rendered.
- B. Not less than one year of clinical experience gained preferably in a hospital of acceptable standards. Preference shall be given to candidates whose clinical experience includes three months hospital work in pediatrics and a similar period in infectious diseases.

#### II. Special qualifications:

- A. Pending the development of a reserve of personnel having graduate training in public health work the following minimum qualifications shall apply as a standard in the selection of medical officers of health for jurisdictions of less than 50,000.
  1. Candidates for appointment shall be not more than 35 years of age when first specializing in public health work. Preference shall be given to candidates having had one or more years' experience in the general practice of medicine.
  2. Personnel selected shall already have had or shall agree to take before assuming duty, from three to six months training in a local health organization properly qualified to supervise a course of field training or a graduate course of instruction in public health of not less than three months duration in a university, one-third of which shall be spent in a well organized local health department qualified to supervise field training.
- B. For health officers of jurisdictions having populations of more than 50,000; for staff positions with state health departments; and for positions having the responsibility of supervisory and consultant service, the following standard of qualifications shall apply:
  1. Not less than one year in residence at a recognized university school of public health in which the following shall have been the main educational training:
    - a. Such training in biostatistics as will give the individual a sound conception of the mass phenomena of disease, familiarity with the methods of collecting, recording and studying statis-



- tics on vital phenomena and ability to interpret the results of the analysis of such material.
- b. Some knowledge of general or theoretical epidemiology and training in the collection, recording, analysis and interpretation of epidemiological information regarding the commoner diseases, including occupational diseases and industrial hazards.
  - c. Familiarity with the general historical background of health administration, a general knowledge of the forms and methods of operation of health departments of the national government, and of the states and local units, and acquaintance with the standard procedures of health administration.
  - d. Sufficient knowledge of public health bacteriology and immunology to permit the performance personally of the simple diagnostic procedures, the interpretation of laboratory reports and familiarity with the general methods of administration and operation of public health laboratories.
  - e. General knowledge of the usual methods of water purification and sewage disposal, sufficient to enable the individual intelligently to advise the local authorities in securing engineering advice and in undertaking new procedures.
  - f. Familiarity with the dangers from, and the general methods of securing protection against, diseases transmitted by foods.
  - g. Sufficient familiarity with the clinical aspects of the commoner communicable diseases to serve as a basis for developing skill in differential diagnosis and advising as to treatment; complete and accurate knowledge of the possibilities, limitations and practical methods of immunization against communicable diseases.
  - h. Sufficient knowledge of the epidemiology and clinical aspects of tuberculosis to enable the individual to plan and administer methods of prevention.
  - i. Sufficient knowledge of the epidemiologic, clinical and social aspects of venereal disease to enable the individual intelligently to plan and administer preventive procedures.
  - j. Familiarity with the principles of nutrition. He should possess a knowledge of basic food requirements. Not only those that are necessary to life, but those which represent optimum conditions for production of the greater vigor and stamina. He should have sufficient knowledge to recognize those actual clinical entities that may be produced by a faulty dietary.
  - k. Sufficient familiarity with the clinical aspects of the common occupational diseases to serve as a basis for developing skill in differential diagnosis and advising as to treatment, and accurate knowledge of the possibilities, limitations and practical methods of control of occupational diseases.
2. Not less than six weeks of field experience under proper supervision in a suitable health organization.

III. Occasional exceptions to the foregoing standards for medical officers may be made but only when candidates for positions have, through experience and practical training, proved ability to perform successfully the duties of the position for which application is made.

IV. Standards for health officers of jurisdictions having less than 50,000 population shall be progressively advanced as rapidly as training facilities become sufficiently well developed and adequate reserves of trained personnel are established. It is doubtful that the time is near at hand when a year's resident training in a recognized university school of public health may be required of students for positions in the smaller health jurisdictions but progressive improvement of personnel training may be secured through graduate training subsequent to employment, as well as by increase of personnel. Preference should be given to medical officers meeting the higher standard of qualifications outlined under Section II.

### MAY DAY—CHILD HEALTH DAY 1938

May Day—Child Health Day will again be commemorated in Michigan on Sunday, May 1, and the preceding and following days by public and private agencies carrying on child welfare activities. Miss Marjorie Delevan, director of the Bureau of Education, has been appointed as Michigan May Day chairman.

"Speed children on the road to health" is the national slogan for the 1938 celebration. Every community will be urged to make full use of its resources for insuring to children safe birth, normal growth, and protection against disease and accident in their progress from infancy to maturity.

### SPECIMEN CONTAINERS NEEDED

The laboratories of the Michigan Department of Health are being handicapped by a shortage of available specimen containers. Large quantities of these containers which have been shipped to local health officers and physicians have never been used. The Bureau of Laboratories is anxious to return these containers to active service. Physicians who have a supply of the containers on hand which are not being used are urged to pack them up and send them to the Bureau of Laboratories at Lansing, postage collect.

### DIABETES IN MICHIGAN

Despite the improved treatment which insulin has made possible, the rapidly increasing mortality from diabetes in Michigan is a matter of grave concern, according to a statistical survey of this disease made by the Bureau of Records and Statistics. Diabetes today is listed among the ten major causes of death; a generation ago it was of minor significance.

The death rate from diabetes has risen from 13.07 per 100,000 population in 1907 to 24.92 in 1936. The 1936 rate is the highest ever recorded in Michigan and indicates a 90 per cent increase in diabetes mortality during one generation.

A very definite change in the sex distribution of diabetes deaths has been indicated. In 1907, of the 352 deaths due to diabetes, 47 per cent were males and 53 per cent were females. In 1936 there were 1,266 deaths and 39 per cent of these were males and 61 per cent were females.

The seasonal distribution of diabetes deaths also indicated that the number of deaths is materially higher during the colder months. Dividing the year into two parts—May to October and Novem-



ber to April—the investigators found that 45 per cent of the deaths occurred during the first or warm period and that 55 per cent occurred in the November to April period.

The age distribution of diabetes deaths in Michigan again substantiates the findings that insulin is of especial value in the treatment of diabetes in the younger age groups. In 1907, 15.7 per cent of the male diabetes deaths occurred in men under 20 years of age. By 1936 this figure had declined to two per cent. In 1907 the female deaths under 20 years of age accounted for 10.6 per cent of the female mortality. This had declined to 2.1 per cent in 1936.

After the age of 45 the number of diabetes deaths increases rapidly in both sexes. In 1907 male deaths occurring under the age of 45 accounted for 35 per cent of the total male diabetes mortality with 65 per cent of the male deaths occurring at the age of 45 and over. This had changed in 1936 to 9.5 per cent under the age of 45, and 90.5 per cent in the age group 45 and over.

In the female group, 23.5 per cent of the female deaths from diabetes in 1907 were recorded in the age group under 45 years and 76.5 per cent in the older age group. By 1936 only 8 per cent of the female diabetes deaths occurred under the age of 45 with 92 per cent occurring in the age group 45 and over.

#### **NO ANTIPNEUMOCOCCIC SERA DISTRIBUTED**

The Michigan Department of Health has notified all full-time health officers and superintendents of state institutions that the Department laboratories are not yet ready to undertake distribution of anti-pneumococcic sera either to institutions or to the medical profession generally.

Some therapeutic sera is now being produced by the laboratories for a special study being carried on in Receiving Hospital in Detroit under the auspices of the Commonwealth Fund. The supply of available sera, however, does not warrant distribution in any other cases at present. The State Health Department expects within the next year to have the necessary facilities for the production of sufficient serum to start free distribution in areas where it will accomplish the greatest possible good.

#### **DR. BARRETT TO HEAD INGHAM HEALTH DEPARTMENT**

The health committee of the Ingham County board of supervisors has selected Dr. C. D. Barrett, director of the Bureau of Communicable Diseases of the Michigan Department of Health since 1931, to head the recently created Ingham County Health Department. Dr. Barrett expects to complete the organization of the new department by April 1.

In his new capacity, Dr. Barrett will direct the Michigan Training Center for public health personnel which will be operated in conjunction with the Michigan Department of Health and the University of Michigan. Headquarters for the department and training center will be at Mason.

#### **PREVALENCE OF COMMUNICABLE DISEASES**

The two diseases which are of most concern to health officials at present are measles and smallpox. According to expectancy, measles is quite prevalent. During January and February the greater number of cases has come from Detroit and vicinity. However, rather extensive outbreaks involving a high percentage of the population have occurred in a few other localities, notably in the Upper Peninsula. From Detroit and other places the disease has

spread throughout the state and is now occurring in numerous localities. Whole blood, convalescent serum and placental extract are being used more extensively than ever before for modification or prevention of the disease in children under four years of age who are known to have been exposed. It is believed that efforts along this line will keep to a minimum the number of deaths.

Smallpox has continued to spread in the Upper Peninsula from the original focus of infection in Gogebic County. At present, cases have appeared in seven of the western counties in the Upper Peninsula and from this same focus of infection to at least one county, Ogemaw, in the Lower Peninsula.

A number of foci of infection, all apparently from unconnected sources, have occurred in the southern part of the state. Here, the greatest number of cases have occurred in Monroe County, possibly due to a smoldering infection continuing from the outbreak of a year ago. Sporadic cases have occurred in other counties, namely, Berrien, Branch, Calhoun, Washtenaw, Oakland, Genesee, Ottawa, and the city of Detroit.

Scarlet fever, while quite prevalent in a number of communities and more especially in rural areas, is on the whole somewhat less in incidence than for the same period of a year ago. This reduction in the number of cases is due in most part to a lower incidence in Detroit.

An extensive milk-borne outbreak of typhoid fever occurred during the month of February in Muskegon and vicinity. The epidemiology of the outbreak has been well established and the source, a carrier, located. So far, there has occurred a total of 46 cases and 5 deaths. The milk involved was not pasteurized.

#### **NEW BUREAU DIRECTOR APPOINTED**

Dr. Filip Forsbeck has been appointed by Commissioner Don W. Gudakunst to succeed Dr. C. D. Barrett as director of the Bureau of Communicable Diseases. Dr. Forsbeck has served as epidemiologist with the Michigan Department of Health since 1932, becoming assistant to the commissioner in charge of pneumonia and typhoid fever control last year. He is a graduate of the University of Chicago Medical School. Previous to coming to Michigan, Dr. Forsbeck served as epidemiologist with the Massachusetts Department of Health and as research assistant at Rockefeller Institute. The new director is a fellow of the American Public Health Association and secretary of the Epidemiology Section of the association. He is also a member of the American Epidemiological Society. Tuberculosis, pneumonia, typhoid and syphilis control activities will be correlated under the direction of Dr. Forsbeck.

#### **NURSING ADVISOR RESIGNS**

Mrs. Helen deSpelder Moore has resigned her position as nursing advisor with the Division of Public Nursing to accept a new post with the State Welfare Department as assistant inspector of hospitals. Miss Mable Munro continues to act as chief nurse of the Department's nursing division.

#### **COMMITMENT OF TUBERCULOSIS CASES**

Commitment of persons afflicted with tuberculosis to an approved hospital as provided under Section 2a, Act 93, P.A. 1937, has been carried out by the Michigan Department of Health in several cases recently where such persons were a source of danger to others. Probate judges of Clinton, Hillsdale and Lapeer counties have already signed such



commitments following the petition of the Department.

Thus, both local and state health officials have been provided with effective means for controlling the so-called incorrigible case of tuberculosis. Tuberculous individuals who are spreaders of infection but who are unwilling to take proper treatment or to maintain isolation for the protection of their families and the public may now be com-

mitted to a tuberculosis hospital by the county probate court providing the local health officer or the state health commissioner can show that such an individual is a menace to others. With this legal weapon as a last resort, local health officers are finding it less difficult to secure hospitalization of recalcitrant individuals who have heretofore avoided adequate treatment as a protection for others as well as themselves.

## GOLFERS' SPECIAL TO 'FRISCO

for the A.M.A. Convention, June 13-17, 1938



At Del Monte

**Ocean Voyage from New York to New Orleans (Six Days) on the S.S. Dixie**

**New Orleans—Houston—Galveston—San Antonio—Los Angeles—Del Monte—San Francisco!**

**Return thru Portland—Seattle—Vancouver—Lake Louise—Banff!**

**Seven Games of Golf—Sightseeing—Entertainment—a Day with Hollywood Stars**

**Non-golfers as well as golfers (and their ladies) invited.**

### YOU OWE YOURSELF THIS WONDERFUL TRIP

Under sponsorship of the American Medical Golfing Association. For itinerary and further information drop a card to Dr. Walt P. Conaway, Pres., AMGA, 1723 Pacific Ave., Atlantic City, N. J.



## ◆ General News And Announcements ◆

### *The One Hundred Per Cent Club of the Michigan State Medical Society*

1. Ingham County Medical Society
2. Luce County Medical Society
3. Manistee County Medical Society
4. Muskegon County Medical Society
5. Newaygo County Medical Society
6. Oceana County Medical Society
7. Ontonagon County Medical Society
8. Shiawassee County Medical Society

These county medical societies are the first to record 100 per cent paid membership for the year 1938. Dues for 1938 are now payable and are being received daily from the various county medical society secretaries. See your County Secretary today and help your Society become one of the first members of the "One Hundred Per Cent Club for 1938."

*Be sure to read your American Medical Association Journal of February 12th.*

*The Tulsa County Medical Society of Tulsa, Oklahoma, has appointed Mr. Lloyd Stone as its Executive Secretary.*

*Dr. Parker Heath of Detroit announces the association of Dr. Windsor Davies in the practice of Ophthalmology after April 1, 1938.*

*Dr. Martin Hoffmann of Eloise, was guest speaker before the February 15 meeting of the St. Clair County Medical Society which met in Port Huron. Doctor Hoffmann spoke on "Mental Hygiene."*

*"In this large and varied country, a nationally administered system of public medical care is hardly conceivable."—Michael M. Davis, in New England Journal of Medicine.*

*Dr. A. M. Hume, a past president of the Michigan State Medical Society, was a recent visitor in the Executive Office of the Michigan State Medical Society, 2020 Olds Tower, Lansing.*

*Dr. Martin Hoffmann, Eloise, Michigan, presented a paper to the Bay County Medical Society on the subject of "Psychiatry" on March 9. The meeting was held at the Hotel Wenonah in Bay City.*

*Dr. Charles G. Johnston, Professor of Surgery, Wayne University, spoke to the members of the St. Clair County Medical Society on March 1. His subject was "Intestinal Obstruction."*

*Dr. Walter G. Maddock of the University Department of Surgery, Ann Arbor, spoke to the members of the Ionia-Montcalm County Medical Society on February 8. Doctor Maddock's subject was "Surgery of the Biliary Tract."*

*Mayor Norman H. Weiner of Albion addressed the February meeting of the Battle Creek Academy of Medicine on the subject "The Return of Home Rule."*

*"A Camera Story" of the manufacture of Chesterfield Cigarettes—a very interesting brochure—is available by dropping a postal to Mr. W. D. Carmichael, Vice President of Liggett and Myers Tobacco Company, 212 Fifth Avenue, New York, N. Y.*

*The Michigan State Dental Society has appointed as its new Executive Secretary Mr. Henry C. Gerber, formerly Executive Secretary of the Toledo (Lucas County) Academy of Medicine. Mr. Gerber will be located in Lansing after April 1.*

*Dr. Willard Van Hazel, thoracic surgeon, of St. Luke's Hospital, Chicago, spoke before the Eaton County Medical Society on March 17, at its meeting in Charlotte. His subject was "Empyema and Surgical Conditions of the Chest."*

*Ask this question of all detail men who seek your business: "Does your firm advertise in THE JOURNAL of the Michigan State Medical Society, and does it exhibit at the annual conventions of the M.S.M.S.?"*

*Support those who support you!*

*The annual banquet of the Phi Beta Pi Medical Fraternity will be held at the Fort Shelby Hotel on April 30, 1938. Dean Raymond B. Allen will serve as Toastmaster and Dr. Clarence E. Umphrey will speak, his subject being "Medicine Branches Out."*

*Hillsdale County physicians met on March 24 in Hillsdale for the purpose of establishing a trained group of physicians for marriage counselling. Following dinner, the group heard a paper on "Contraceptive Techniques" given by Dr. Harold A. Furlong of Pontiac.*

*Going to the A.M.A. Convention in San Francisco next June? Hotel reservations must be secured immediately in order to obtain the best accommodations. Write Dr. F. C. Warnshuis, 450 Sutter Street, San Francisco. Give the names of members of your party, type of accommodations desired, rates, dates of arrival and departure.*

*Dr. Henry J. Vanden Berg and Dr. Charles Ingersoll, both of Grand Rapids, were guest speakers at the March 8th meeting of the Ionia-Montcalm Medical Society held in Greenville. Doctor Vanden Berg's subject was "The Physician's Responsibility in Cancer." Doctor Ingersoll spoke on "Practical Problems in X-Ray Therapy."*

*The Michigan Board of Pharmacy has received report which leads it to believe that some of the pharmaceuticals shipped into Michigan, direct to physicians' offices, are not true to label or catalog formula. Board of Pharmacy inspectors are collecting samples of pharmaceuticals for analysis from physicians. A laboratory report will be sent to co-operating doctors.*

*The Ohio State Medical Association is arranging a "President's Special" from Ohio to the A.M.A. meeting in San Francisco next June. Guest of honor on the trip will be Dr. J. H. J. Upham, President of the A.M.A. Members of the M.S.M.S. are cordially invited to join the "President's Special" to San Francisco. For details write Mr. C. S. Nelson,*



## GENERAL NEWS AND ANNOUNCEMENTS

Executive Secretary, Ohio State Medical Association, Hartman Theatre Bldg., Columbus, Ohio.

\* \* \*

On Saturday, March 5, the staff of the Ford Hospital entertained forty-four surgeons of the Brooklyn and Long Island Chapters of the American College of Surgeons. A program of clinics was presented. At 9 a. m. a list of operations available was presented. From 11 a. m. on, guests met in the surgical amphitheater where Dr. Roy McClure spoke on the decrease of thyroid surgery in Michigan due to the general use of iodized salt. A full program was presented by other members of the Ford staff.

\* \* \*

The East Side Medical Society of Detroit, a branch of the Wayne County Medical Society, writes its membership as follows: "Both the Society and you, Doctor, are losers if you are not taking an active part in our meetings. No society can attain its greatest influence unless its members all take an active part in its deliberations. We feel our society has much to offer you. May we direct your attention to a new feature in our program: the presentation and discussion of unusual cases from the practices of our own members, which affords an excellent opportunity for all members to participate."

\* \* \*

Crippled and Afflicted Child Commitments for the month of February, 1938, were as follows:

Crippled Child: Total of 277 of which 100 went to University Hospital; and 177 went to miscellaneous hospitals. Of the above, Wayne County wrote 84 orders of which 4 went to University Hospital and 80 went to miscellaneous hospitals. Afflicted Child: Total of 1193, of which 183 went to University Hospital; and 1010 went to miscellaneous hospitals. Of the above 255 were sent to hospitals from Wayne County, of which 14 went to University Hospital and 241 to miscellaneous hospitals.

\* \* \*

Organizational talks by officers and by the Executive Secretary of the Michigan State Medical Society during the past month include:

Speaker	City	Date	Organization	Subject
Wm. J. Burns	Ann Arbor	2/8	Washtenaw County Medical Society and Ann Arbor Lawyers Club	"Medical Legislation"
Dr. L. F. Foster	Grand Rapids	2/9	Kent County Medical Society	"Organization of the M.S.M.S."
Dr. Henry Cook	Grand Rapids	2/9	Kent County Medical Society	"Organization of the M.S.M.S."
Dr. Henry Luce	Grand Rapids	2/9	Kent County Medical Society	"Organization of the M.S.M.S."
Dr. Henry A. Carstens	Grand Rapids	2/9	Kent County Medical Society	"Organization of the M.S.M.S."
Wm. J. Burns	Grand Rapids	2/9	Kent County Medical Society	"Organization of the M.S.M.S."
Dr. L. F. Foster	Adrian	2/16	Lenawee County Medical Society	"Filter System"
Dr. F. B. Miner	Adrian	2/16	Lenawee County Medical Society	"P. R. C. Program"
Dr. H. H. Cummings	Adrian	2/16	Lenawee County Medical Society	"State Society"
Wm. J. Burns	Adrian	2/16	Lenawee County Medical Society	"AMA Survey"
Dr. Dean Hart	Charlotte	2/17	Eaton County Medical Society	"P. R. C. Program"
Wm. J. Burns	Charlotte	2/17	Eaton County Medical Society	"What's Going On"
Dr. L. F. Foster	Battle Creek	2/22	Battle Creek Academy of Medicine	"The Filter System."
Wm. J. Burns	Ionia	2/23	Ionia Rotary Club	"Your County Medical Society —a Community Asset"
Dr. L. F. Foster	Bay City	2/23	Bay County Medical Society	"AMA Survey"
Dr. L. F. Foster	Cadillac	2/24	Wexford County Medical Society	"AMA Survey"
Dr. L. F. Foster	St. Johns	3/1	Clinton County Medical Society	"AMA Survey"
Wm. J. Burns	Battle Creek	3/1	Calhoun County Medical Society	"AMA Survey"
Dr. L. F. Foster	Lapeer	3/3	Lapeer County Medical Society	"AMA Survey"
Dr. P. R. Urmston	Lapeer	3/4	Lapeer County Medical Society	"State Society"
Dr. T. F. Heavenrich	Lapeer	3/4	Lapeer County Medical Society	"State Society"
Dr. L. F. Foster	Lapeer	3/4	Lapeer County Medical Society	"AMA Survey"
Dr. L. F. Foster	Owosso	3/10	Shiawassee County Medical Society	"AMA Survey"
Dr. L. G. Christian	Owosso	3/10	Shiawassee County Medical Society	"AMA Survey"
Dr. P. R. Urmston	Owosso	3/10	Shiawassee County Medical Society	"AMA Survey"
Wm. J. Burns	Owosso	3/10	Shiawassee County Medical Society	"AMA Survey"
Dr. Wilfrid Haughey	East Lansing	3/10	College Vocational Study Group	"Medicine as a Career"
Dr. L. F. Foster	Wahjamega	3/11	Tuscola County Medical Society	"AMA Survey"
Dr. L. F. Foster	Saginaw	3/15	Saginaw County Medical Society	"AMA Survey"
Dr. L. F. Foster	Alma	3/17	Gratiot-Isabella-Clare County Medical Society	"AMA Survey"
Wm. J. Burns	Hastings	3/21	Hastings Rotary Club	"Your County Medical Society —a Community Asset"
Dr. L. F. Foster	Caro	3/21	Caro Rotary Club	"What a County Medical Society Means to a Community"
Dr. L. G. Christian	Grand Ledge	4/7	Eaton County Medical Society	"The Health League"

Speakers on scientific subjects are available for meetings of county medical societies. Write the Executive Office, 2020 Olds Tower, Lansing for talks on:

Cancer	Tuberculosis
Maternal Health	Preventive Medicine
Mental Hygiene	Social Aspects of Sickness
Syphilis	Occupational Diseases.

\* \* \*

"The Stethoscope" is the name of the new monthly bulletin of the Berrien and Cass County Medical Societies. The first issue was published as of March 1, 1938. Dr. A. F. Bliesmer of St. Joseph is the editor.

A brief editorial says: "We hope this instrument will prove of value in prognosticating the symptoms and prescribing a remedy for the ailments which are common problems of all medical bodies. This new "Stethoscope" is unique in that you can speak through it as well as keep an ear on the heart beats of the Berrien-Cass Medical Societies."

\* \* \*

Your friends.—The following firms are some more of your friends who entered technical exhibits at the 1937 Grand Rapids Convention. The products of these firms are Council approved, where indicated, and are worthy of your consideration:

The C. V. Mosby Company, St. Louis, Missouri.  
Parke, Davis & Company, Detroit, Michigan.  
The Pelton & Crane Company, Detroit, Michigan.  
Pet Milk Company, St. Louis, Missouri.  
Petrologar Laboratories, Inc., Chicago, Illinois.  
Philip Morris & Co., Ltd., Inc., New York, New York.  
Physiotherapy Equipment Company, Detroit, Michigan.  
Physicians Equipment Exchange, Detroit, Michigan.  
Picker-X-Ray Corporation, Chicago, Illinois.  
Professional Management, Battle Creek, Michigan.

\* \* \*

"As medicine is practiced at the present time, the first year generally entails a loss. In the second year the margin of net income is very small, and it is not until the third year when a physician is about thirty-one years old, that he has an average net income of \$1,700 or \$1,800. Seven or eight years elapse before his gross income reaches the level that is average for all practitioners. The peak is attained in the seventeenth or eighteenth year. Income then tends to decline, until, at about the thirty-fifth year, it is approximately the same as in the eighth."—Physicians and Medical Care, by E. L. Brown, Russell Sage Foundation.



*Preventive Medicine* is the subject of the Graduate Conferences for physicians sponsored in Detroit jointly by the Wayne County Medical Society and the Detroit Department of Health. The Conferences are held at Herman Kiefer Hospital Auditorium, Detroit. All physicians are invited.

- April 20**  
10:00 A.M. "Evaluation of Present Immunization Methods."—Dr. LeRoy D. Fothergill, Harvard University.  
11:00 A.M. "New Concepts and Developments of Treatment of Communicable Disease." Dr. Edwin H. Place, City Hospital, Boston.
- April 27**  
10:00 A.M. "The Mental Problems of the Adolescent."—Dr. Wm. S. Sadler, Chicago, Ill.  
11:00 A.M. "The Recognition and Treatment of the Early Case of Mental Illness."—Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C.

\* \* \*

The Metropolitan Life Insurance Company of New York has published a very attractive little booklet entitled "How Safe is Home?" The booklet is intended for lay perusal. It presents several pictures of carelessness in the home and by a very ingenious covering of the picture with red cellophane, the same picture is made to illustrate how accidents may be easily avoided. According to the latest figures of the National Safety Council, accidents in the home totaled 32,000 deaths in 1937, and were responsible for nearly half of all temporary disabilities resulting from accidents. One scarcely realizes that home is such a dangerous place. Mark Twain was wont to comment how dangerous a thing it was to go to bed inasmuch as the great preponderance of deaths took place in bed.

\* \* \*

The American College of Surgeons' Library is eager to have a complete file of THE JOURNAL of the Michigan State Medical Society on its shelves. Some of its missing numbers run back to 1916.

Physicians having any of the following numbers of the M.S.M.S. JOURNAL, who wish to contribute them to the A. C. S. Library, may send the volumes to 2020 Olds Tower, Lansing.

#### Missing M.S.M.S. Journals

- 1916, Vol. 15—missing January through June, September, October and December.  
1917, Vol. 16—missing number 1, January.  
1919, Vol. 18—missing numbers 1 through 5, 8, through 12 and index and title page.  
1920, Vol. 19—missing numbers 1 through 7.  
1922, Vol. 21—all numbers missing.  
1923, Vol. 22—all numbers missing.  
1924, Vol. 23—all numbers missing.  
1925, Vol. 24—missing October.  
1928, Vol. 27—missing December; and pages 105-106; 199-204; 335-338.  
1929, Vol. 28—all numbers missing.  
1930, Vol. 29—all numbers missing.  
1931, Vol. 30—all numbers missing.  
1932, Vol. 31—all numbers missing.  
1933, Vol. 32—all numbers missing.  
1934, Vol. 33—missing January through May, and November.  
1935, Vol. 34—missing June.  
1936, Vol. 35—all numbers missing.

\* \* \*

Your title is "M.D."—use it. There is wide-spread abuse of the title "Doctor." Legal procedures have failed to correct the situation. We have attorney generals' opinions, opinions from the State Board of Registration in Medicine, offers of cooperation from the Department of Health, the county prosecutor's office, etc., etc. Some results are obtained in specific instances, but under present procedures a violation must occur before action can be taken. Let us as physicians, endowed with the degree M.D., start to place emphasis on that degree. No one else can use it. Use "M.D." in your speech, in your correspondence, on your signs, prescription pads, bill heads, et cetera. Gradually the public will start to discriminate. In this positive way we can gradually but most effectively offset the parasitical influence of so-called "doctors" who are not M.Ds. At the same time, we can continue to refer specific abuses to the

proper authorities.—C. E. UMPHREY, M.D., President Wayne County Medical Society, Detroit.

\* \* \*

The Annual Clinic of the Ingham County Medical Society will be held in Lansing, Hotel Olds, on Thursday, April 28, 1938, beginning at 1:00 p. m. The program which is being arranged by Dr. John M. Wellman and his Committee, is one of outstanding interest. All members of the Michigan State Medical Society are cordially invited to attend. There is no registration fee.

- 1:00 P. M.—Registration.  
1:30-2:30 P. M.—Dr. H. G. Poncher, Chicago, Ill.  
"Clinical Implications of Recent Advances in Nutrition in Infancy and Childhood."  
2:30-3:30 P. M.—Dr. Edward H. Rynearson, Rochester, Minn.  
"Protamine Insulin," or "Hyperinsulinism."  
3:30-4:30 P. M.—Dr. James M. Pierce, Cincinnati, Ohio.  
"The Management of Abnormal Labor."  
4:30-5:30 P. M.—Dr. Frederick Christopher, Evanston, Ill.  
"The Diagnosis and Treatment of Right Lower Quadrant Lesions."  
5:30-7:00 P. M.—Social Hour.  
7:00-8:30 P. M.—Banquet, Ballroom.  
Toastmaster, Mr. C. W. Otto, Secretary, Lansing Chamber of Commerce.  
8:30 P. M.—Dr. Frederick A. Collier, Ann Arbor, Mich.  
"Surgical Aspects of the Biliary Tract."

\* \* \*

A course in Ophthalmology and Otolaryngology in connection with the Department of Postgraduate Medicine of the University of Michigan will be given from April 21 to April 27, inclusive. A short course in Roentgenology is also announced for July 25 to July 30, 1938, at the University Hospital, Ann Arbor. There will be two courses given in Roentgenology, a six weeks' course as listed on the program which appeared in the March number of THE JOURNAL, and the short intensive course announced as above.

\* \* \*

*Occupational Disease Law.*—Under the 1937 Occupational Diseases section of the Workmen's Compensation Law, an employee in an occupational disease case (a) must have contracted one of the occupational diseases mentioned in the schedule of diseases (31); (b) such disease must be caused by the particular process or occupation described in the schedule appearing opposite such disease (under the strict interpretation); (c) the disease must be due to causes and conditions which are characteristic of and peculiar to the particular trade, occupation, process, or employment; (d) the employee must have been injuriously exposed to the hazards of such disease after October 29, 1937, the effective date of the Act; (e) the disease must have been due to the employment in which the employee was engaged, and contracted therein, or in a continuous employment similar to the one in which he was engaged, within twelve months previous to the date of the disablement, whether under one or more employers.

In occupational disease cases, notice must be given to the employer of the "contraction" of the disease within a hundred and twenty days from the date of disablement.

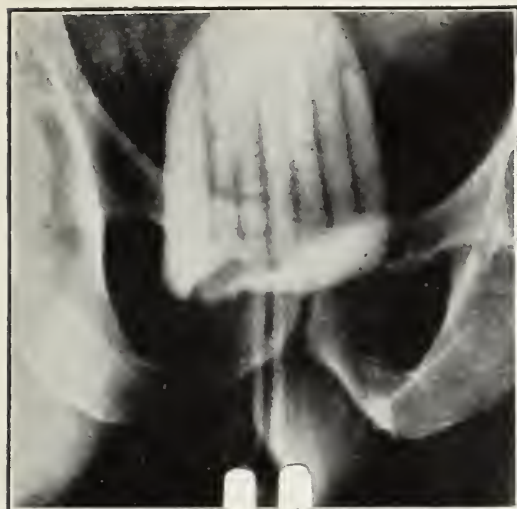
\* \* \*

Dr. A. William Lescoghier was elected president of Parke, Davis & Company on March 1. He has been actively connected with the Company for about thirty years, having been General Manager and a Director since 1929.

Dr. Lescoghier succeeds Oscar W. Smith, who had been President of the Company for sixteen years until his death on February 7. Dr. Lescoghier was born in Detroit, a few blocks from the laboratories of which he now becomes the chief executive. After graduating from high school he worked a year or two in the laboratories and then entered Detroit College of Medicine. In 1909, following his graduation from college, he became a member of the

(Continued on Page 368)





Prostatic Applicator in Position During Treatment. Covering Prostate and Extending Beyond to the Vesicles.



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. . . Acute non-specific prostatitis and seminal vesiculitis . . . In this type of case with distressing symptoms, relief has been prompt in all cases. Great shrinkage in the size of the gland took place rapidly and clearance of pus from the prostate was rapid and striking . . .

. . . Acute or sub-acute gonorrheal prostatitis and seminal vesiculitis . . . Results in this series of acute cases have been extraordinarily satisfactory . . .

. . . In the chronic cases, reduction in the size of the prostate uniformly takes place . . . Patients have almost uniformly reported improvement in initial symptoms . . ."—Journal of Urology—Page 681, June, 1936.

# ELLIOTT TREATMENT

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If you have occasion to treat any of the following, you will be intensely interested in the Elliott Treatment Handbook, furnished free to physicians on request. The data contained in this handbook is compiled from the published reports of the profession.

### MALE PELVIS

Acute prostatitis  
(with or without abscess)  
Chronic prostatitis  
(and complications)  
Vesiculitis  
Cystitis  
Urethritis—non-specific

### FEMALE PELVIS

Acute or chronic salpingitis  
Post-Abortal peritonitis  
Post-Partum infections  
Pelvic Abscess  
Parametritis (frozen pelvis)  
Tubo ovarian abscess  
Gonorrhea—acute and chronic  
Cystitis  
Urethritis—gonorrheal and non-specific  
Dysmenorrhea  
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Clinical results over a period of years in hundreds of institutions and by thousands of physicians in their private practice show that satisfactory results may be expected in the above mentioned indications.

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Parke-Davis Research Staff, giving special attention to biological problems. In 1918 he was named Assistant Director of the Research and Biological Laboratories, in which capacity he was in charge of the production of serums, vaccines, antitoxins, and other biological products. In 1925 he was made Director of the Department of Experimental Medicine, and in 1928 he was appointed to the position of Assistant-to-President. In 1929 he was elected General Manager, which position he has occupied since that time.

\* \* \*

A five and one-half days' ocean voyage from New York to New Orleans on the \$2,500,000 S. S. Dixie starts off the "Golfers' Special" on a delightful trip to San Francisco for the American Medical Association Meeting next June. Sponsored by the American Medical Golfing Association, the Special will feature four games of golf on the trip to the coast and include sightseeing stops in New Orleans, Houston, Galveston, San Antonio, Los Angeles (a trip through Hollywood studios), and Del Monte.

The Twenty-Fourth Tournament of the American Medical Golfing Association will be held in San Francisco at the luxurious Golf and Country Club on Monday, June 13, 1938. This is a thirty-six hole annual competition.

On the return journey of the "Golfers' Special" through Portland, Seattle, Vancouver, Lake Louise and Banff, two games of golf and an all-day boat trip up Puget Sound will be enjoyed.

Non-golfers as well as medical golfers, and their ladies, will be welcome on the "Golfers' Special." The all-inclusive summer rate on the Special train will include air-conditioned deluxe Pullmans, with compartments and drawing rooms only.

For full particulars on the "Golfers' Special," and on the A.M.G.A. tournament in San Francisco, write the President of the A.M.G.A., Dr. Walt P. Conaway, 1723 Pacific Avenue, Atlantic City, New Jersey; or Bill Burns, Executive Secretary, 731 N. Capitol Avenue, Lansing, Michigan.

\* \* \*

### Chiropractors May Not Use Title "Doctor"

Raymond W. Starr, Attorney General for the State of Michigan, rendered the following opinion on December 23, 1937:

"Act Number 145 of the Public Acts of 1933 does not confer upon the holders of certificates or licenses to practice chiropractic the right to practice medicine or to use the title 'Doctor' or its abbreviation."

\* \* \*

### Doctors Deny Plea for State Medicine

A committee of 430 physicians which last fall submitted "certain principles and proposals to medical organizations in the hope that they might contribute to a discussion of the subject of medical care in the United States and suggest the lines along which effort may be made by voluntary local, state and Federal agencies to improve medical care," announced today that it had no intention of championing state medicine and was not at odds with the American Medical Association.

The committee said it believed "the principles and proposals present certain positive proposals which, if considered thoughtfully, may contribute to constructive action by the profession through the appropriate channels provided by medical organizations."—*Detroit Free Press*, March 10, 1938.

\* \* \*

### American Board of Obstetrics and Gynecology

The oral, clinical, and pathological examinations for Group A and Group B applicants will be held in San Francisco, California, on Monday and Tuesday, June 13 and 14, 1938.

An informal dinner for the Diplomates of this Board, their wives and others interested in the work of the Board, will be held at the Palace Hotel, San

Francisco, on Wednesday evening, June 15, 1938, at seven o'clock. Dr. William D. Cutter, Secretary of the Council on Medical Education and Hospitals of the American Medical Association, will address the group, and the successful candidates of the preceding two days' examinations will be introduced in person. Tickets, at \$2.25 each, may be obtained in advance from Dr. Joseph L. Baer, 104 S. Michigan Avenue, Chicago, Illinois, or at the door. Reservations should be made in advance if possible.

Application for admission to the June 1938 Group A examinations must be on file in the Secretary's Office before April 1, 1938.

Application blanks and booklets of information may be obtained from Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

## EXHIBITORS AT 1938 MICHIGAN STATE MEDICAL SOCIETY CONVENTION

Book-Cadillac Hotel, Detroit, September 20, 21, 22, 1938:

Name of Company	City	Booth No.
Akron Truss Company.....	Detroit, Mich.	75
A. S. Aloe Company.....	St. Louis, Mo.	4
Arlington Chemical Company..	Yonkers, N. Y.	15
Bard-Parker Company, Inc....	Danbury, Conn.	7
Bilhuber-Knoll Corporation....	Jersey City, N. J.	38
Burroughs Wellcome & Co., Inc. ....	New York, N. Y.	12
S. H. Camp Company.....	Jackson, Mich.	22
Coca-Cola Company .....	Atlanta, Ga.	70
Cottrell-Clarke, Inc. ....	Detroit, Mich.	64
R. B. Davis Sales Corp.....	Hoboken, N. J.	66
Detroit X-ray Sales Co.....	Detroit, Mich.	59
Dictaphone Sales Corp.....	Detroit, Mich.	71
Duke Laboratories, Inc.....	Long Island City, N. Y.	52
General Electric X-ray Corp..	Chicago, Ill.	53
Gerber Products Company.....	Fremont, Mich.	45
Gordon Shoe Co.....	Detroit, Mich.	72
Hack Shoe Company.....	Detroit, Mich.	3
Hanovia Chemical & Mfg. Co..	Newark, N. J.	5, 6
J. F. Hartz Company.....	Detroit, Mich.	54
H. J. Heinz Company.....	Pittsburgh, Pa.	43
Holland-Rantos, Inc.....	New York, N. Y.	36
Horlick's Malted Milk Corp...	Racine, Wis.	28
G. A. Ingram & Company.....	Detroit, Mich.	62, 63
Jones Metabolism Equipment Co. ....	Chicago, Ill.	8
The Jones Surgical Supply Co.	Cleveland, Ohio	56
A. Kuhlman & Company.....	Detroit, Mich.	69
Lea & Febiger Company.....	Philadelphia, Pa.	55
Lederle Laboratories .....	New York, N. Y.	25
Libby, McNeill & Libby.....	Chicago, Ill.	68
Liebel-Flarsheim Company ...	Cincinnati, Ohio	50
J. B. Lippincott Company.....	Philadelphia, Pa.	9
M. & R. Dietetic Labs.....	Columbus, Ohio	47
Mead Johnson & Company.....	Evansville, Ind.	29, 30
Medical Arts Pharmacy.....	Grand Rapids, Mich.	26, 27
Medical Case History Bureau..	New York, N. Y.	40
Medical Protective Company...	Wheaton, Ill.	39
The Mennen Company.....	Newark, N. J.	48
Merck & Company.....	Rahway, N. J.	10, 11
The Wm. S. Merrell Company...	Cincinnati, Ohio	46
C. V. Mosby Company.....	St. Louis, Mo.	2
Nestle's Milk Products Co....	New York, N. Y.	16
W. B. Davis & Company.....	Detroit, Mich.	17, 18, 19, 20
Parke & Crane Company.....	Detroit, Mich.	57, 58
Pet Milk Sales Corp.....	St. Louis, Mo.	41, 42
Petrolagar Laboratories, Inc..	Chicago, Ill.	67
Philip Morris Company, Ltd...	New York, N. Y.	21
Physicians Equip. Exchange...	Detroit, Mich.	73
Picker X-ray Corporation.....	Chicago, Ill.	23
Pocahontas Fuel Company.....	Detroit, Mich.	74
Professional Management ....	Battle Creek, Mich.	65
Randolph Surgical Supply Co..	Detroit, Mich.	13, 14
Sandoz Chemical Works, Inc...	New York, N. Y.	24
W. B. Saunders Company.....	Philadelphia, Pa.	49
Smith, Kline & French Labs...	Philadelphia, Pa.	34, 35
E. R. Squibb & Sons.....	New York, N. Y.	44
Frederick Stearns & Co.....	Detroit, Mich.	60, 61
Taylor Instrument Companies...	Rochester, N. Y.	32, 33
Van Hoosen Farm.....	Rochester, Mich.	37
Vernor's Gingerale .....	Detroit, Mich.	1
Wall Chemicals Company.....	Detroit, Mich.	31
The Ziemer Company.....	Pittsburgh, Pa.	51
Zimmer Manufacturing Co....	Warsaw, Ind.	76

Your patronage of these friends who are supporting the Michigan State Medical Society is earnestly recommended.



**ANNUAL POSTGRADUATE COURSE IN PEDIATRICS, APRIL 18, 19, 20, 1938**

Conducted under the auspices of the American Academy of Pediatrics, The University of Michigan, Wayne University, and Michigan State Medical Society at the Henry Ford Hospital, Children's Hospital of Michigan, Herman Kiefer Hospital.

**PROGRAM****April 18, 1938—The Henry Ford Hospital**

- 9:00 a. m. The Newborn.....Dr. W. C. C. Cole  
Current concept in the understanding and management of asphyxia and hemorrhage. Role of sedatives and analgesics in the production of asphyxia. Resuscitation.
- 10:00 a. m. Clinic.....Dr. J. A. Johnston and Staff
- 11:00 a. m. Feeding in Infancy and Childhood  
Dr. J. C. Montgomery
- 2:00 p. m. Tuberculosis in Childhood.....  
Dr. Bruce Douglas  
(25 minutes.)  
Syphilis in Childhood.....  
Dr. P. J. Howard  
(25 minutes.)
- 3:00 p. m. Clinic.....Dr. J. A. Johnston and Staff
- 4:00 p. m. Rheumatic Fever, Chorea and Rheumatic Carditis.....Dr. D. J. Levy

**April 19, 1938—The Children's Hospital**

- 9:00 a. m. Non-tuberculous Infections of the Chest.....Dr. James Wilson
- 10:00 a. m. Clinic.....Dr. T. B. Cooley and Staff
- 11:00 a. m. Disorders of the Blood for Which There Exists Specific Therapy....  
Dr. T. B. Cooley
- 2:00 p. m. Therapy of Infections of the Nose, Throat and Ear.....Dr. J. M. Robb
- 3:00 p. m. Clinic.....Dr. James Wilson
- 4:00 p. m. Present Status of Those Conditions Amenable to Treatment with Sulphanilamide.....Dr. E. E. Martmer

**April 20, 1938—Herman Kiefer Hospital**

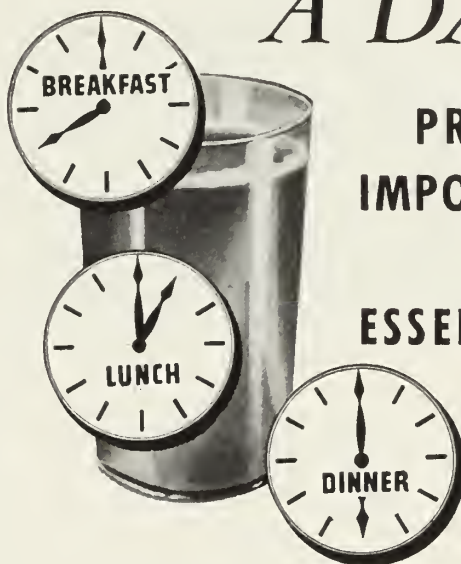
- 10:00 a. m. Current Practice in Prophylaxis of Contagious Disease.  
Dr. LeRoy Fothergill, Harvard Medical School.  
Current Practice in the Treatment of Contagious Disease.  
Dr. Edwin Place, Director, Contagious Service, Boston City Hospital.
- 2:00 p. m. A symposium by representatives of various specialties—ophthalmology, otology, cardiology, orthopedics—on the physical appraisal of the normal school child.

Under the Detroit plan, school examinations are conducted by the family physician. The need for a more general understanding of what constitutes an adequate "screening" process for the commoner defects is generally admitted, and if this plan is to function satisfactorily, a plan of detecting at least the gross departures from the normal in vision, hearing, posture, and heart and lung defects, as well as a uniform set of recommendations on prophylaxis, is imperative.

Committee for the Academy:

THOMAS B. COOLEY  
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### E.R.A. HOME AND OFFICE MEDICAL CARE BY COUNTIES IN THE LAST SIX MONTHS OF 1937

An analysis of the costs reveals the following:

In 29 counties or 36 per cent, less than 10 per cent of the indigent cases received medical service.

In 14 counties or 17 per cent, less than 15 per cent of the indigent cases received medical service.

In 15 counties or 18 per cent, less than 20 per cent of the indigent cases received medical service.

In 16 counties or 19 per cent, 20 per cent or more of the indigent cases received medical service.

In 9 counties or 10 per cent of the 83 counties accurate records were not kept.

The industrial group of counties allowed more indigent cases to receive medical service.

30 counties or 36 per cent of all counties spent less than 50 cents per case each month.

17 counties or 20 per cent of all counties spent less than 75 cents per case each month.

16 counties or 19 per cent of all counties spent less than \$1.00 per case each month.

19 counties or 23 per cent of all counties spent more than \$1.00 per case each month.

1 county or 1 per cent of all counties did not keep accurate records.

*The Emergency Relief Commission through Mr. George F. Granger states that in a number of counties, Superintendents of the Poor and Township Supervisors handle medical services, while in other counties (particularly in the industrial areas) this is not apt to be true. The above findings, based on ERA statistics only, do not include such medical service given independently by township and county authorities.*

### Classification of Counties of Michigan Used by the State E. R. A.

I Industrial Counties	II Southern Agricultural Counties	III Northern Cut-Over Counties	IV Upper Peninsula Counties
Bay	Allegan	Alcona	Alger
Calhoun	Barry	Alpena	Baraga
Genesee	Berrien	Antrim	Chippewa
Ingham	Branch	Arenac	Delta
Jackson	Cass	Benzie	Dickinson
Kalamazoo	Clinton	Charlevoix	Gogebic
Kent	Eaton	Cheboygan	Houghton
Muskegon	Gratiot	Clare	Iron
Oakland	Huron	Crawford	Keweenaw
Saginaw	Ionia	Emmet	Luce
St. Clair	Lapeer	Gladwin	Mackinac
Wayne	Lenawee	Grand	Marquette
	Livingston	Traverse	Menominee
	Macomb	Iosco	Ontonagon
	Montcalm	Isabella	Schoolcraft
	Ottawa	Kalkaska	
	Sanilac	Lake	
	Shiawasee	Leelanau	
	St. Joseph	Manistee	
	Tuscola	Mason	
	Van Buren	Mecosta	
	Washtenaw	Midland	
		Missaukee	
		Montmorency	
		Newaygo	
		Oceana	
		Ogemaw	
		Osceola	
		Oscoda	
		Otsego	
		Presque	
		Isle	
		Roscommon	
		Wexford	

Additional statistics, showing costs per county, will be published in subsequent issues of THE JOURNAL.

JOUR. M.S.M.S.

# MEDICAL CARE OF THE INDIGENT UNDER MICHIGAN E.R.A.

MEDICAL RELIEF CASES AND MEDICAL COSTS  
July 1 to December 31, 1937

County	Avg. No. Relief Cases Per Month	Avg. No. Med. Relief Cases Per Month	Total Medical Relief Costs 6 Mo. Period	Avg. Monthly Med. Cost Per Case
Alcona	91	22	\$17.23	6.29
Alger	138	7	255.69	6.56
Allegan	198	14	284.80	3.31
Alpena	92	1	7.35	3.68
Antrim	184	23	743.78	5.31
Arenac	104	9	228.94	4.09
Baraga	179	15	360.72	4.10
Barry	175	33	875.09	4.38
Bay	789	158	6,357.21	6.70
Benzie	183	11	276.75	4.39
Berrien	612	39	873.91	3.78
Branch	213	42	1,006.91	4.00
Calhoun	970	128	2,737.95	3.57
Cass	258	29	1,368.01	7.95
Charlevoix	219	30	890.43	4.97
Cheboygan	170	43	1,623.00	6.34
Chippewa	280	14†	3,002.75*	†
Clare	192	22	858.40	6.55
Clinton	180	24	821.73	5.79
Crawford	95	20	496.11	4.24
Delta	778	62	1,058.77	2.84
Dickinson	720	49	1,026.86	3.52
Eaton	298	37	1,246.78	5.59
Emmet	192	11†	4,535.98*	†
Genesee	2,350	†	19,911.18*	†
Gladwin	90	4	78.70	3.42
Gogebic	1,189	153	6,710.76	7.32
Gd. Traverse	213	5	155.68	4.87
Gratiot	383	63	2,014.93	5.32
Hillsdale	206	33	907.97	4.63
Houghton	1,040	172	2,901.73	2.82
Huron	219	9	325.38	6.14
Ingham	2,170	293	14,666.35	8.36
Ionia	470	90	2,581.35	4.77
Iosco	145	18	666.41	6.06
Iron	524	99	2,131.92	3.61
Isabella	136	35	1,442.49	6.87
Jackson	2,057	418	8,634.44	3.44
Kalamazoo	2,597	598	9,701.45	2.70
Kalkaska	128	28	939.00	5.66
Kent	3,993	656	11,675.81	2.97
Keweenaw	110	14	543.79	6.32
Lake	211	14	534.42	6.60
Lapeer	159	37	919.39	4.18
Leelanau	84	5	124.70	4.16
Lenawee	315	50	2,237.64	7.41
Livingston	131	29	1,870.97	10.69
Luce	93	5†	1,465.30*	†
Mackinac	214	37	2,574.82	11.70
Macomb	608	73	2,850.33	6.54
Manistee	286	34	1,179.74	5.81
Marquette	556	15	500.78	4.43
Mason	285	6†	364.37*	†
Mecosta	160	12	357.93	5.19
Menominee	390	38	11,231.62	4.12
Midland	140	36	1,623.96	7.45
Missaukee	142	36	1,169.50	5.41
Monroe	343	53	1,512.87	4.76
Montcalm	479	90	2,123.65	3.93
Montmorency	72	5	141.24	4.56
Muskegon	1,453	354	8,029.31	3.78
Newaygo	313	78	2,026.64	4.35
Oakland	1,530	459	8,764.84	3.18
Oceana	149	24	522.58	3.68
Ogemaw	102	7†	485.23*	†
Ontonagon	233	10†	1,060.66*	†
Osceola	170	19	630.75	5.44
Oscoda	77	9	368.36	6.95
Otsego	82	7	701.44	2.51
Ottawa	201	18	436.85	3.97
Presque Isle	81	3	74.74	3.74
Roscommon	86	9	401.72	7.58
Saginaw	1,287	145	3,839.71	4.42
Sanilac	193	10	251.20	4.05
Schoolcraft	122	20	388.95	3.02
Shiawassee	400	30	574.53	3.07
St. Clair	888	78†	6,086.20*	†
St. Joseph	293	33	775.16	3.91
Tuscola	176	3	29.45	1.73
Van Buren	292	2†	227.93*	†
Washtenaw	525	32	604.13	3.18
Wayne	22,410	4,702	93,383.62	5.52
Wexford	346	6	9.35	.27
Hagerman Lake Camp	88			
Muskegon Camp	126			
Total	61,668	10,060	233,061.02	3.86

†Incomplete Cases. ‡Not Available. \*Not included in Total.



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and Hospitals of the A. M. A.

In some few counties of Michigan, cash is included in the relief budget for indigent families to cover medical needs. In such cases, the Michigan ERA has no record of the amount of cash spent by the welfare client for medical care. However, the above chart indicates almost the maximum total of costs for medical care of those on relief in Michigan during the last six months of 1937.

\* \* \*

### Private and Industrial Practice

A standard for evaluating the relationship between private practice and industrial practice of medicine has been developed by the Wayne County Medical Society. The following resolution was published in the *Detroit Medical News* of March 14, 1938:

"RESOLVED, That the Wayne County Medical Society, through its Council and Ethics Committee, in the interests of the private practice of medicine and the ultimate good of the health of the people in this community, continue to conscientiously apply the Principles of Ethics of the American Medical Association to every type of case presented for review, and be it further

RESOLVED, That in the interests of clarity, efficiency, and the harmonious advancement of medical science on all fronts, the following "Scope of Duties and Procedures of a Contract Physician" be adopted for the guidance of the Council and the Ethics Committee in their deliberations:

#### General:

(1) Medical aid in compensation units shall be none other than required by the compensation laws or that required in case of true emergency.

(2) A whole time contract physician shall not treat any member of a worker's family who is not employed at the institution.

(3) He shall be responsible for the efficiency and scope of application of the nursing and first aid personnel and equipment; there shall be no relegation of work requiring expert medical attention to these groups.

(4) When a worker requires treatment beyond that provided by the Compensation Laws, he shall be instructed to consult his own practitioner who shall accept the industrial physician as consultant in regard to his re-employment.

(5) He shall make examination of applicants for employment and give advice as to their selection.

(6) He shall make periodic examination of employees when necessary and especially those exposed to special hazards and those returning to work after prolonged illness.

(7) He shall give advice to the management regarding:

(a) Hygiene of the factory or institution.

(b) Health conditions of the workers.

(c) Occurrence of risk and dangerous hazards.

(d) Accident prevention arrangements.

(e) Factory legislation concerning health and safety and the special diseases to which the particular industry exposes the worker.

#### Consultation:

Where it is necessary for a contract physician to examine a private patient, or one under the care of another contract physician, it is proper to do this only after the recognized procedure of a consultation.

When a contract physician doubts the ability of a worker to resume his work following a prolonged illness for which the private physician has approved, the contract physician shall consult with the private physician at the earliest possible moment.

#### Medical Records:

Workers' records that are maintained by the industrial medical officer are documents as confidential as those in private practice and must remain in the cus-

(Continued on Page 374)

## *Chicago Tumor Institute*

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The Chicago Tumor Institute opened March 21, 1938. It offers consultation service to physicians in the diagnosis and treatment of cancer and radiation facilities for cancer patients.

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tody of the medical officer or his deputy; access to these records must not be allowed to any other person, save only to another registered medical practitioner and then only at the request and consent of the worker.

### Signs:

Placards, signs, or cards, used for advertising physicians employed by the factory or insurance company are unethical, with the following exception: It is permissible to have one card for each first aid station in the plant, containing the names and phone numbers of staff physicians, and this card is to be always accessible to the medical director or person in charge.

### Contracts:

Written contracts which outline the scope of duties of a contract physician are legal documents of importance and would be to advantage of all parties concerned; it shall be a mark of great courtesy and coöperation on the part of the contract physician to send a copy of such contract to the local society.

\* \* \*

### CREDIT IS DUE

The following members of the Michigan State Medical Society were present at the postgraduate assemblies of the Michigan State Medical Society Annual Meeting in Grand Rapids, September 27, 28, 29, 30, 1937:

Drs. A. O. Abraham, Hudson; R. C. Allen, St. Joseph; George E. R. Anthony, Flint.

Drs. Henry F. Balconi, Brooklyn; F. Elizabeth Barrett, Kalamazoo; S. E. Barnett, Detroit; L. L. Barnett, Detroit; F. Herbert Bartlett, Muskegon; George Bates, Kingston; Theodore I. Bauer, Lansing; M. B. Beckett, Allegan; E. H. Beernink, Grand Haven; W. C. Beets, Grand Rapids; Harry S. Berman, Detroit; Andrew Biddle, Detroit; Elton P. Billings, Grand Rapids; H. C. Bodmer, Kalamazoo; A. T. Bonathan, Flint; W. P. Bope, Decatur; Gabriel D. Bos, Holland; Albert J. Bower, Greenville; J. G. Bowers, Muskegon; Lewis E. Bracey, Sheridan; James B. Bradley, Eaton Rapids; Robert Braunsdorf, Detroit; C. W. Brayman, Cedar Springs; Robert S. Breakey, Lansing; Stanley E. Bryant, Dowagiac; George W. Brooks, Tustin; O. H. Bruegel, East Lansing; John D. Bryce, Detroit; Earl P. Bunce, Trufant; Max Burnell, Flint; Frederick J. Burt, Holly; Earle J. Byers, Grand Rapids; G. M. Byington, Detroit.

Drs. Mary B. Campbell, Detroit; James E. Caraway, Wayne; Thomas J. Carney, Alma; Herman J. Carson, Detroit; Ward L. Chadwick, Grand Rapids; Donald Chandler, Grand Rapids; Carl A. Coates, Detroit; Horace R. Cobb, Kalamazoo; Fred H. Cole, Detroit; J. E. Cooper, Battle Creek; E. H. Corley, Jackson; F. L. Covert, Gaines; Ferdinand Cox, Jackson.

Drs. Adolph F. Dasler, Muskegon Hts.; J. S. Detar, Milan; Stuart L. DeWitt, Grand Haven; Clement F. Derezhinski, Muskegon; N. W. Diebel, Detroit; Harold T. Donahue, Cass City; Robert J. Douglas, Muskegon; S. J. Drummond, Casnovia; Chas. F. DuBois, Alma; Paul W. DuBois, Detroit; W. J. DuBois, Grand Rapids; Chas. E. Dutchess, Detroit; Francis W. Dwyer, Detroit.

Drs. Cecil W. Ely, Saginaw; Clayton S. Emery, St. Joseph.

Drs. Stephen Fairbanks, Luther; L. W. Faust, Grand Rapids; D. W. Fenton, Reading; S. Albert Fiegel, Sturgis; C. C. Flinn, Allegan; Southard T. Flynn, Flint; Frances A. Ford, Detroit; L. M. W. Frank, Detroit; O. H. Freeland, Mason; Rudolphus W. Fuller, Crystal.

Drs. L. Galdonyi, Detroit; Frank W. Garber, Jr., Muskegon; Evan Garrett, Hartford; Nathaniel Gates, Detroit; James W. Gauntlett, Traverse City; C. J. Geenen, Grand Rapids; Willis Geerlings, Fremont; Stephen M. Gelenger, Flint; J. W. Gething, Battle Creek; George R. Goering, Flint; L. I. Gist, Coldwater; Lucile R. Grant, Grand Rapids; Newton H. Greenman, Decatur; John F. Gruber, Cadillac; G. L. Gundry, Grand Blanc; E. S. Gurdjian, Detroit; A. B. Gwinn, Hastings.

Drs. Ralph Hager, Manton; B. C. Hall, Pompeii; Carl W. Hammer, Oxford; Cyril F. Hanff, Springport; Frank W. Hannum, Muskegon; D. Hargrave, Eaton Rapids; A. W. Harper, Flint; C. D. Hart, Newberry; A. R. Hayton, Shelby; John Heneveld, Muskegon; Alton Deane Hobbs, St. Louis; A. Hoekman, Constantine; Alfred E. Holland, Belding; A. Holm, LeRoy; W. Leonard Howard, Battle Creek; A. A. Hoyt, Battle Creek; M. C. Hubbard, Vestaburg; Perry R. Hungerford, Concord; F. Pitkin Husted, Bay City; S. P. Huysck, Sunfield.

Drs. M. C. Igloe, Big Rapids; C. F. Ingersoll, Grand Rapids.

Drs. John B. Jackson, Kalamazoo; Joseph Johns, Ionia; E. B. Johnson, Allegan; J. H. Jones, Dowagiac.

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Drs. E. Vander Berg, Holland; B. Van Der Kolk, Hopkins; N. S. Vann, Grand Rapids; John W. Ver Duin, Grand Haven; E. Vonder Heide, Detroit; J. D. Vyn, Grand Rapids.

Drs. Roger V. Walker, Detroit; John H. Wax, Detroit; Lewis R. Way, Traverse City; N. E. Wayson, Detroit; Arthur E. West, Kalamazoo; John O. Wetzel, Lansing; W. A. Wickham, Jackson; Israel Wiener, Detroit; Clifford M. Wilcox, Owosso; Robert J. Williams, Monroe; Norman D. Wilson, Jackson; Walter J. Wilson, Sr., Detroit; William G. Winter, Holland; Victor Hugo Wolfson, Mount Clemens; G. H. Wood, Luther.

Drs. T. G. Yeomans, St. Joseph; Wm. Rae Young, Lawton.

Dr. Jos. Zimmerman, Traverse City.

*The above list represents the registration of Wednesday, September 29, 1937. The registration of Thursday will be published in a succeeding issue of THE JOURNAL.*

### American Express Tour to A.M.A.

Physicians and their families are evincing a very keen interest in arrangements made by the American Express Travel Service to see America en route to and returning from the San Francisco Convention of the A.M.A.

The beauty and relaxation of such scenes as the Indian Detour in New Mexico, the Grand Canyon of Arizona, Los Angeles and the beauties of southern California, Santa Catalina Island, the famous Columbia River Highway in Oregon, Seattle, Washington, Victoria, Vancouver, Lake Louise and Banff in the Canadian Rockies, Yellowstone National Park,



## IN MEMORIAM

Colorado Springs and many others, will be enjoyed.

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Pedestrian (to boy leading a skinny mongrel pup):

"What kind of a dog is that, my boy?"

Boy: "This is a police dog."

Pedestrian: "That doesn't look like a police dog."

Boy: "Nope, it's in the secret service."

## IN MEMORIAM

### Edgar Burr Babcock

Dr. Babcock was born in Lamont, Ottawa County, Michigan, on November 16, 1857, and there he obtained his early education. In 1884, upon receiving his M.D. from the Detroit College of Medicine, he began to practice in Kalkaska. After one year he moved to Williamsburg but four years later he returned to Kalkaska and made his permanent home there.

Outside of his professional work, he found time for an active part in the industrial and educational as well as in the fraternal, political and religious affairs of his community. Some years ago he had an interest in a local woodworking factory, for many years he served on the Kalkaska Board of Education and he was a Mason of high standing. Politically, he was a strong Republican and his was the distinction of having attended as a delegate the convention which nominated McKinley in 1896. Beginning in 1899, there was a period of several years when he served Kalkaska as Postmaster. As a Baptist, he was deeply interested in the religious needs of his village, viewing them from the broad as well as from the sectarian point of view. In his earlier years he was active in athletics and he always loved fishing and the outdoor life. In his profession he was capable and he followed new developments in medicine with keen interest, being until recent years a member of his state and national medical organizations.

On June 13, 1883, he married Miss Mattie B. Darby, who passed away on December 25, 1932. There were no children. On July 29, 1936, he married Mrs. Myrtle Sharp, who survives him.

Over one year ago he suffered an apoplectic stroke, which put limitations on his bodily activities but did not dull his mind, and he was able to continue a certain amount of office-work. Death finally occurred on December 6, 1937.

As a physician many a family loved him. As a fellow-practitioner he was fair and his counsel was valuable. Genial and kindly was he as a friend and always the courteous gentleman.

## Among Our Contributors

Dr. Maxwell J. Lick was graduated from the University of Pennsylvania School of Medicine in 1912 and is a member of Phi Beta Kappa. He was resident physician to the Philadelphia Lying-in Charity Hospital, resident physician to the University of Pennsylvania Hospital for two years. He has taken postgraduate work in various leading clinics in the United States and foreign clinics. He is a Fellow of the American College of Surgeons, past president of the Erie County Medical Society and president of the Medical Society of the State of Pennsylvania.

\* \* \*

Dr. Thomas Parran was graduated from St. John's College, Annapolis, with an A.B. degree in 1921. In 1915, he received the degree of M.D. from the College of Medicine of Georgetown University. From 1930 to 1936, Dr. Parran was Commissioner of Health for the State of New York, and was appointed Surgeon General of the U. S. Public Health Service in 1936. Dr. Parran is a Fellow of the New York Academy of Medicine, American College of Physicians, Royal Sanitary Institute of Great Britain, American Association of Physicians, American Society for the Control of Cancer and the American Social Hygiene Association. He is also a member of the Technical Board of the Milbank Memorial Fund, and a Scientific Director of the International Health Division of the Rockefeller Foundation. Dr. Parran is a past president of the American Public Health Association and a member of the Executive Board; and vice president of the National Tuberculosis Association.

\* \* \*

Dr. George Sewell was graduated from the Detroit College of Medicine in 1912, and has limited his work to urology. Dr. Sewell is Associate Urologist to Receiving Hospital, Assistant Urological Surgeon to Harper Hospital, and Attending Urologist to Herman Kiefer Hospital. Dr. Sewell is also Clinical Instructor in Urology at Wayne University College of Medicine and is associated at the Detroit Department of Health, Division of Social Hygiene.

\* \* \*

Dr. Gabriel Steiner graduated from the University of Strassburg Medical School in 1911, where he was a lecturer in the Department of Neurology from 1913 to 1918. From 1919 to 1936 he was professor of neurology at the University of Heidelberg, Germany, Medical School, and was head of the laboratories of the University Hospital (Psychiatrisch-neurologische Klinik). In 1923 he was appointed to the chair of neuropathology of the University of Heidelberg.

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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**THEORETICAL PRINCIPLES OF ROENTGEN THERAPY:** Edited by Ernst A. Pohle, M.D., Ph.D., F.A.C.R., Professor of Radiology, Chairman, Department of Radiology and Physical Therapy, University of Wisconsin, Madison, Wisconsin. Contributors: R. R. Newell, Professor of Medicine (Radiology), Stanford University Medical School; Ernst A. Pohle, M.D., Ph.D., Professor of Radiology, University of Wisconsin; K. Wilhelm Stenström, Ph.D., Professor of Biophysics, University of Minnesota Medical School; Lauriston S. Taylor, Ph.D., Physicist, Bureau of Standards, Washington, D.C., and Francis Carter Wood, M.D., Director, Institute of Cancer Research, Columbia University. Octavo, 271 pages, illustrated with 132 engravings, cloth, \$4.50, net, 1938. Washington Square, Philadelphia: Lea & Febiger.

**CLINICAL ROENTGEN THERAPY:** Edited by Ernst A. Pohle, M.D., Ph.D., F.A.C.R., Professor of Radiology, Chairman, Department of Radiology and Physical Therapy, University of Wisconsin, Madison, Wisconsin. Foreword by George W. Holmes, M.D., Roentgenologist to the Massachusetts General Hospital and Clinical Professor of Roentgenology in Harvard Medical School, Boston, Massachusetts. Octavo, 819 pages, illustrated with 199 engravings and a colored plate. Cloth, \$10.00, net. Published 1938. Washington Square, Philadelphia: Lea & Febiger.

This last is a companion volume to the author's Theoretical Principles of Roentgen Therapy; it is also a work of composite authorship. The two volumes, namely the Principles, and Clinical Roentgen Therapy, are advantageous to one who wishes a thoroughly comprehensive knowledge of the subject of x-ray therapy. The subjects have about the same relation to each other as Materia Medica and Ther-

apeutics. The former volume is the work of three radiologists and two physicists. The subjects dealt with are the physics of roentgen rays, roentgen therapy apparatus, dosimetry, radiobiology and radiopathology, and protection from roentgen rays.

Clinical Roentgen Therapy is essentially a work on radiotherapeutics applied to those pathological conditions in which roentgen therapy has been found effective. The standardization of the dose, namely, the "r" unit, reduces radiotherapy to a measureable basis which is a marked advance over the old hit and miss methods. Clinical Roentgen Therapy is the product of seventeen roentgenologists selected on account of their training and experience in the department assigned to each. It is a thoroughly practical work with descriptions of disease and definite directions regarding the application of radiation therapy. No one should attempt roentgen therapy before he has mastered the information these two volumes offer.

**A TEXTBOOK OF HEMATOLOGY.** By William Magner, M.D., D.P.H., Pathologist, St. Michael's Hospital, Toronto; Lecturer in Pathology, University of Toronto. With 3 Charts. 3 Colored Plates, 23 Text Illustrations. 395 Pages. Handsome, Washable Cloth Covers, \$4.50. Philadelphia: P. Blakiston's Son & Co., Inc.

The author has had many years experience as a hospital pathologist and as a teacher. The book presents a balanced account of the theory and practice of hematology to serve the needs of practicing physicians, students, laboratory workers and teachers of medicine. Normal and abnormal hemopoiesis, the structure and functions of the bone marrow, the etiology of the blood dyscrasias and the clinical and laboratory aspects of disorders of the hemopoietic system are described fully but concisely. The work offers a complete account of modern hematology and is written in an easy and lucid style.

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**PRACTICAL BACTERIOLOGY, HEMATOLOGY AND ANIMAL PARASITOLOGY 9TH EDITION, REWRITTEN, REVISED AND ENLARGED.** By E. R. Stitt, M.D., Sc.D., LL.D., Rear Admiral, Medical Corps, Surgeon General, U.S.N. (Rtd.); Paul W. Clough, M.D., Chief of Diagnostic Clinic, Johns Hopkins Hospital; Assoc. in Medicine, Johns Hopkins University, and Mildred C. Clough, M.D., formerly Fellow in Bacteriology and Instructor in Medicine, Johns Hopkins University. 208 Illustrations, 4 in Colors. 961 Pages. Handsome Washable Fabric Covers, \$7.00. Philadelphia: P. Blakiston's Son & Co., Inc.

More than ten years have elapsed since the eighth edition was published and the many important practical advances have necessitated a complete rewriting to permit their incorporation in a clear and orderly arrangement throughout the book. More space has been given to interpretation and diagnostic significance of laboratory methods and the data have been still further correlated with the clinical picture. The book considers all available types of laboratory tests and an index of useful procedures is included for assistance in the selection of appropriate tests.

**A TEXTBOOK OF OPHTHALMOLOGY.** By Sanford R. Gifford, M.A., M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago; Attending Ophthalmologist, Passavant Memorial, Cook County, Wesley Memorial and Evanston Hospitals. 492 pages with 249 illustrations. Philadelphia and London: W. B. Saunders Company, 1938. Cloth, \$4.00 net.

As the author declares in his preface, this volume presents the essential facts of modern ophthalmology for the general practitioner with emphasis on those which are really important. The subjects ordinarily dealt with in a discussion of this specialty are all included. The work is well illustrated and well arranged. There is really more in the book than should be undertaken by the general practitioner. His interest, however, in such subjects as Operation for Cataract, particularly the technic, will be only academic. It will not burden his memory to know how it is done. It is hoped, however, that his discretion will induce him to refer cases requiring operative treatment to the ophthalmologist.

#### "Harofe Haivri"

The tenth anniversary issue of "Harofe Haivri" embodies a wealth of excellent medical material. Under the able editorship of Dr. Moses Einhorn it has achieved phenomenal success. Among the notable medical articles the following deserve mention:

Sparteine; Clinical Notes—SOLOMON SOLIS-COHEN, M.D.

Pharmacological Study of Locusts and Grasshoppers—DAVID I. MACHT, M.D. (formerly of Johns Hopkins University).

Glycosuria: Its Significance and Differentiation—GERSHON GINSBURG, M.D.

Neurofibromatosis—NOAH E. ARONSTAM, M.D.

Toxemias of the Later Months of Pregnancy—AARON DUBNOVE, M.D.

Exogenic Obesity—Its Treatment with Dietetic and Medical Measures—GEORGE ARANY, M.D. (Karlsbad, Czechoslovakia).

Dr. Solomon Solis-Cohen and Dr. David I. Macht, two of the foremost Jewish physicians in the United States, are of international reputation.

Brief excerpts of the articles published in the pure Hebrew appear as appendices in the English language so as to facilitate perusal of the Hebrew text. Another excellent feature is the glossary; "Milon," a Hebrew-English lexicograph which enhances the proper comprehension of the Hebrew text to a considerable degree.

From the historical point of view, there appears an article by Dr. Israel Hadash, on a Hebrew manuscript by Shem Tob ben Joseph Falaquiera, entitled "Versified Vademecum on the Care of the

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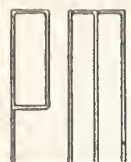
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Body and Soul" (1225 to 1290). Falaquiera was a Spanish philosopher and poet, some think even a physician. The original is in the Oxford collection. It is a manuscript of great and abiding interest for the student of medical history. Professor Alexander Marx, of the Jewish Theological Seminary, has a valuable essay on old Hebrew Medical manuscripts, which is likewise of profound historical significance. From a typographical point of view, this issue has reached a high degree of excellence. Dr. Leon M. Herbert has a very excellent and valuable introduction on the progress of *The Hebrew Medical Journal* from its very inception.

This issue numbers over 300 pages and is published semi-annually. It is noteworthy, that at last Palestine medicine has an exact fixed terminology due to the painstaking and most elaborate efforts of Saul Chernichowsky, the poet, who himself is a physician. His dictionary has been adopted by the medical world in Palestine and it was a gigantic task. The next issue, which will appear in April, will also have an article by him, as well as other valuable material and will be reviewed upon its appearance.

**ANNUAL REPRINTS OF THE REPORTS OF THE  
COUNCIL ON PHARMACY AND CHEMISTRY** of  
the American Medical Association for 1936, with the  
Comments That Have Appeared in the JOURNAL. Cloth.  
Price, \$1. Pp. 104. Chicago: American Medical Association.

This book is essentially a record of the negative actions of that distinguished body, the Council on Pharmacy and Chemistry of the American Medical Association; that is, it sets forth the findings concerning medicinal preparations which the Council has voted to be unacceptable for recognition and use by the medical profession. Many of the reports record outright rejection or the rescinding of previous acceptances; others report in a preliminary way on products which appear to have promise but are not yet sufficiently tested or controlled to be ready for general use by the profession.

Among the reports on out-and-out unacceptable products are Amend's Solution and the "Igol" products, iodine preparations marketed under misleading or unacceptable claims, the latter under an uninformative proprietary name; Androstine-Ciba, claimed to be a testicular extract and found to be an irrational combination of inactive preparations, marketed with unwarranted and misleading claims; Gadoment, a preparation of cod liver oil in a wax base with zinc oxide benzoin and phenol, proposed for use in the treatment of burns, cuts and minor skin irritations, found unacceptable as being an unoriginal product of insufficiently declared composition marketed under a coined proprietary name with unwarranted therapeutic claims, and indirectly advertised to the public; the "Carasyll" preparations, which are essentially mixtures of psyllium flour, karava gum and fig flour, marketed with unsubstantiated therapeutic claims under a proprietary name.

In 1934, the Council sponsored an exhaustive report on bacteriophage therapy which pointed out that, in view of the present status of knowledge, no such preparations could be accepted for New and Non-official Remedies. In this volume of the collected Council reports the Council declares the "Phagoid" preparations, a line of bacteriophage products, definitely unacceptable because they are offered to the medical profession with unscientific, unwarranted claims, thus encouraging physicians to use in a routine way medicaments, the therapeutic value of which had not been established, and because the preparations conflicted in other ways with the rules of the Council.

This volume includes a preliminary report on

Trichophytin and Oidiomycin—trichophyton preparations marketed by Lederle Laboratories, Inc. This report is a sequel to the preliminary report on Trichophyton Extract issued in 1932, which postponed consideration to await development of further clinical evidence on Trichophyton therapy. Also included in this volume is a report on the unacceptability of two trichophyton preparations, Dermatomycol and Dermotricofitin, distributed in this country by Ernst Bischoff Co., Inc., under the stated proprietary names without sufficiently declared composition and with unwarranted therapeutic claims.

Other preliminary reports are Refined and Concentrated Antipneumococcic Serum Type VII-Lederle, Present Status of Tetrachlorethylene (since accepted for N.N.R.), Smallpox Vaccine (from Chick Chorio-Allantoic Membrane) -Lilly, and Use of Trichoroethylene for General Anesthesia.

**NEW AND NON-OFFICIAL REMEDIES, 1937.** Containing Descriptions of the Articles Which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1937. Cloth. Price, \$1.50. Pp. 557, LXIV. Chicago: American Medical Association, 1937.

The annual editions of this volume contain all that the busy physician needs to know concerning the newer preparations which he is daily importuned by the detail men of the pharmaceutical manufacturers to use. The remedies listed and described here have been examined and found acceptable by the Council on Pharmacy and Chemistry, the deliberative body charged by the American Medical Association with the performance of this service for the practitioner, who has not the time or means to make the determinations for himself.

Some new drugs have been added in the 1937 edition, the descriptions of which will be found in the groupings to which they belong. There are some noteworthy changes in classification. The various vaso-constrictors, Benzedrine, Ephedrine, Epinephrine and Neo-Synephrin, have been grouped together as phenylalkylamine derivatives under the heading "Epinephrine and Related Preparations." This terminology is in keeping with the Council's policy of avoiding therapeutically suggestive names. Another similar change is the abandonment of the classification "Medicinal Foods" and substitution of a chapter under the title "Vitamins and Vitamin Preparations for Therapeutic Prophylactic Use" in the previous edition. The consideration of other classes of food preparations was long ago transferred to the Council on Foods. The chapter "Organs of Animals" which has heretofore included only endocrine preparations has been expanded by transfers to this heading of the chapters Liver and Stomach Preparations, and Insulin.

The book contains general articles, descriptive of the classification under which the various drugs are listed. According to the preface, more or less thoroughgoing revisions have been made of the articles: Arsenic Compounds; Compounds Containing Trivalent Arsenic; Compounds Containing Pentavalent Arsenic; Bismuth Compounds; Epinephrine and Related Preparations; Iodine Compounds; Iodine Compounds for Systemic Use; Mercury and Mercury Compounds; Pituitary Gland; Salicylic Acid Compounds; Serums and Vaccines; Antipneumococcic Serums; Silver Preparations; Tannic Acid Derivatives.

**A Sure Test**—Suburban Gardener: "I don't seem able to tell my garden plants from weeds. How do you distinguish them?"

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## Foot Disorders in General Practice

DUDLEY P. MORTON, New York (*Journal A. M. A.*, Oct. 2, 1937), states that physiology indicates that intrinsic as well as extrinsic factors are to be considered in foot trouble. Leg muscles and shoes represent extrinsic factors because they are outside the foot itself. In contrast, intrinsic factors are those which, being located within the foot, affect its internal mechanism directly. The two most common external signs of foot disorder are a pronated, unbalanced posture and callus formation on the sole of the foot, behind the second and third toes. Pronation occurs usually as "weak angles" early in child life. Its long recognized association with trouble in the longitudinal arch has not only made it the best known sign of foot disorder but has established it also as a morphologic index by which the degree of trouble is estimated. Both of these signs point directly to a functional deficiency in the first metatarsal segment. Two structural conditions have been identified which are directly responsible for the impaired functional qualities of the first metatarsal segment. They are laxity of its plantar ligaments and shortness of the first metatarsal bone. Functional deficiency of the first metatarsal segment furnishes a basis on which the widely diversified range of symptoms in foot disorders are easily interpreted and understood. Their presence must be supplemented by abusive function—abusive, not from the point of view of what normal feet can stand but because it is excessive to the subnormal capabilities of these feet. The abusive elements are of two major classes: (1)

unfavorable conditions of function, which apply to environmental or personal factors, such as hard floors, city pavements, high heeled shoes and ill health and (2) excessive degrees of function, such as long hours of work on the feet, violent sports and obesity. Symptoms are traceable to two primary sources: (1) uneven distribution of weight on the metatarsal bones with stresses concentrated chiefly on the second, and (2) loss of structural stability on the medial side of the foot. Ordinary disorders of the foot are not difficult to treat and respond readily to a thoughtful and methodical plan of procedure. The important objective to be borne in mind is first to restore a painless condition and then to establish improved conditions of function. This demands equal attention to superficial irritation, deep traumatic and inflammatory changes and disordered mechanics. Instead of presuming all feet to be 100 per cent proficient, various degrees of limited capabilities must be recognized. The identification of primary causes as defects within the foot is most clearly revealed by an analysis of normal function of the foot and its earliest phases of disturbance. Physicians have no reason to doubt their ability to treat the great majority of feet successfully; certainly they are far better qualified to do so than the agencies to which the public now flocks. Responsibility for the more difficult and exaggerated cases may well be shared with, or referred to, the orthopedic surgeon. But, as in other physical ailments these advanced cases will probably comprise less than 10 per cent of the number that the physician will be able to take care of without aid.

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## THE DIAGNOSIS AND TREATMENT OF DISEASES OF THE ADRENAL GLANDS\*

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The number of clinical syndromes which are definitely attributable to disease of the adrenal glands, in the present state of our knowledge, is not very great. The results of recent physiological and biochemical studies, however, are beginning to offer a solution of many problems. As is well known, present knowledge indicates that the two parts of the adrenal—cortex and medulla—are in reality separate anatomical and functional structures. Ever since the discovery and appreciation of this fact, however, the suspicion has remained that the close proximity of these two apparently distinct structures must indicate in some way an in-

terdependence of function. Although both organs have a separate arterial supply, the blood from the cortex flows eventually into the capillary network of the medulla, and most of the blood ultimately is drained from the whole gland by the one venous system of the medulla. The possible significance of this anatomical arrangement is not yet clear.

It is now definitely established that the medulla is the site of formation of adrenalin, and that a clinical syndrome of hyperfunction of the adrenal medulla exists, due to flooding of the body with adrenalin. It is found in medullary tumors. Clinical hyperplasias of the medulla have not been observed. These adrenalin-producing tumors have been called chromaffin-cell tumors, and several other names have also been suggested. They are generally slow growing, encapsulated growths. Often it is possible to remove them successfully, with complete amelioration of the symptoms, and apparent

cure of the patients. Since this is true, the importance of recognizing the clinical signs of this condition, rare though it may be, is obvious. These growths are sharply distinct from adrenal cortical tumors, and a word of description may be in order. The presence of the tumors is characterized by attacks of paroxysmal hypertension, in which other evidence of sympathetic excitation are also exhibited. At irregular intervals, due to mental or emotional stimulation, physical exertion, abdominal pressure, or even stretching or bending into certain postures, the blood pressure will rise sharply, 100 to 150 points above its usual level. The duration of the occurrence of such periodic attacks varies between a few months and a number of years. The frequency of the attacks, as a rule, increases with the duration of the disorder. Intervals of years may elapse but usually they are found to come at the beginning once or twice weekly, and gradually to increase in frequency until they occur daily or several times daily. An

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attack lasting sixteen hours has been reported. In one case recently observed, death occurred, presumably from an attack induced by pressure, subsequent to drinking four glasses of water for a renal function test. The most frequent times of the attacks seem to be in the early morning hours, or upon arising, or in relation to meals. Prior to the onset of this disease, the general health is, as a rule, good. Extreme fatigue and prostration follow the attacks, and no effect on the alarming symptoms has been accomplished by a wide variety of drugs.

The attacks are accompanied by palpitation, vertigo, flushing, difficulty in breathing, profuse sweating, pulsations of the neck vessels, and tremors of the extremities and head. Vomiting is common, usually with nausea. Pulmonary edema frequently occurs. Severe pain usually is present, which may be precordial or epigastric. Usually the hypertension and the accompanying symptoms subside gradually, often over a period of several hours. In two-thirds of the cases which we have studied neither the tumor nor the proximal kidney was felt. In the others a palpable mass was made out, which has been mistaken for the spleen when present on the left side. X-ray and pyelogram studies have been disappointing in that they have never disclosed the presence of a medullary tumor which was not also demonstrable by palpation.

A great proportion of the cases with tumors of the medulla have been bilateral, and the others have been about equally divided as to the side affected. The possibility of inducing attacks of hypertension during operations complicates the picture. In case a normal adrenal is found at the first incision, the shock or pressure may precipitate a release of adrenalin from the other, affected side, and cause a severe attack. The fatal cases usually have pulmonary edema and cardiac enlargement, which are frequently found at autopsy. The tumors are usually described as beefy red and soft, the consistency being compared to that of the enlarged thyroid of Graves' disease. They vary from the size of a cherry or English walnut to that of an orange, kidney or grapefruit. The size seems to bear little relation to the number or intensity of the attacks. Large amounts of adrenalin have been recovered from these tumors and in one case of ours more than seven times the

normal concentration of adrenalin was found in the tumor tissue. It is to be remembered that the clinical history may sometimes be mistaken for neurotic or climacteric disturbances. A proper and early diagnosis is of great importance because of the possibility of surgical removal and cure.

At the present time there is no clinical syndrome which, in our opinion, with existing methods can definitely be associated during life with reduced function of the adrenalin medulla. We will, therefore, pass to a consideration of the conditions of over-function and of under-function of the adrenal cortex. Modern interest in this matter has been greatly heightened because of the discovery of an extract from the adrenal cortex which is effective in maintaining the lives of adrenalectomized animals. A very brief consideration of the function of the cortex is necessary in order to have a proper understanding of the clinical disorders.

The adrenal cortex is now believed to have an intimate relation to sexual development, to carbohydrate metabolism, to protein metabolism, and to the metabolism of mineral salts, sodium and potassium, and water. Very recently evidence has been advanced of its relationship to one of the vitamin B factors, riboflavin.

Studies during the past two years, particularly by Reichstein at Zurich, and by Kendall, and Wintersteiner and Pfiffner in this country, have shown rather clearly that the cortical hormone is a cholesterol-like substance belonging to the group of chemical compounds known as phenanthrenes, of which the sex hormones are also members. It will be recalled that the adrenal cortex is said to resemble the histological appearance of the corpus luteum, and the close chemical relationship of the cortical hormone to the sex hormones offers a suggestive explanation for the frequent occurrences of sexual abnormalities in patients suffering from cortical tumors, in which the metabolism or chemical formation of the cortical hormone may presumably be abnormal. The relationships of the adrenal cortex to carbohydrate and protein metabolism, on the other hand, at the present time are very poorly understood. Attacks of hypoglycemia do sometimes occur and may sometimes be responsible for death in the crises of Addison's disease. Similarly, the muscular weakness may be due to disturbed

carbohydrate metabolism. No less than five separate, although closely related compounds, have now been described by Reichstein, with varying degrees of cortical hormone activity. It is possible, however, that they may each have some special relation to one of these functions.

The effects of excessive or distorted activity seems to be fairly clear in the case of cortical adrenal tumors with their extraordinary symptomatology in the realm of sexual development. As a matter of fact, not only sexual development is perverted but these tumors often have a profound effect upon the general physical development, the structure of the bones, muscles, skin, and upon the mental processes. The general outlines of this syndrome have been better understood recently. The clinical picture has been termed "the adrenocortical syndrome," and while not always typical, has a number of characteristic features.

Cortical tumors are usually soft growths of yellowish color. They are at first well encapsulated but may later grow through and invade other tissues, with localized hemorrhages and areas of necrosis. If metastases occur, they are frequently to the liver and lungs. When the tumors appear in infancy and childhood, they may produce symptoms of precocious puberty, with abnormal hair development, voice changes, mental and physical changes, and obesity and hypertrophy of the sex glands. A child of 18 months recently seen by the writer had the external genitalia of a man with hairy development and obvious precocious mental changes. This case died at operation, at which time a cortical tumor was discovered. A patient reported by Fordyce is said to have carried a bucket of coal weighing 18 pounds across the room shortly after learning to walk, at the age of 20 months. In girls, before the age of puberty, cortical tumors are associated with many of the characters of the precociously adolescent male. Hirsutism and hypertrophy of the clitoris are marked features. It should, however, be borne in mind that this syndrome has also been observed in disorders of the gonads, thymus, and probably of the pineal and pituitary. The adrenal, however, is probably also involved in these cases.

Tumors in the adult lead to virilism and hirsutism, and many cases occur in women who have previously been quite normal.

They are associated with gradual inversion of the sexual characters, both psychic and physical, a change which is sometimes distressingly evident to the patient herself. Hair appears in the body regions where it normally occurs in the male. It is apt to be short, crisp and curly, and may be profuse over the face and thighs. It is also common on the legs and forearms. There is a loss of the feminine psychic reactions, and untidiness and coarseness of voice may occur. There is a loss of normal sex interest. Amenorrhea is the rule. We lay great stress on this fact. In our series, obesity is not a characteristic. In the adolescent the menses fail to appear. In older persons, the breasts flatten and the internal genitalia atrophy. The male characteristics do not appear simultaneously. The beard is often longest delayed. Symptoms sometimes develop very rapidly, but usually it is only after the lapse of several months that the change in the appearance of the patient is manifest. Walters, Wilder and Kepler have especially emphasized the appearance of this syndrome in conditions of adrenal cortical hyperplasia rather than of tumor.

An analogy appears to exist between the suprarenal cortical syndrome and that of hyperthyroidism as well as that of hyperparathyroidism. In each, apparent hyperfunction seems to follow the development either of tumors or of diffuse hyperplasia. Reduction of the mass of functioning tissue in either case, according to the Mayo workers, may be expected to induce return of normal conditions. On the other hand, just as the removal of thyroid or parathyroid tissue may induce myxedema or tetany, so removal of cortical tumors may at times result in acute cortical deficiency. The possibility of supplying the essential cortical hormone for longer or shorter periods, together with salt, until the balance can be reestablished, makes the outlook now decidedly more hopeful in the cases subjected to operation.

Surgical removal of cortical tumors has been followed in a number of well recognized instances by a marked amelioration of the symptoms. A case described by Gordon Holmes, for instance, showed resumption of menstruation after removal of the tumor, and gradual loss of the abnormal hair growth occurred after a few months. Unfortunately, follow-up reports are usually lacking of cases which have been observed



for long periods after removal of these tumors. It is hoped that they will be recorded. Two of my own cases, both in young women, showed a resumption of menstruation within three or four months after removal of the tumor. In neither case was there much change in the appearance of the beard. One has continued to shave regularly and has been unwilling to cooperate to the extent of allowing the facial hair to grow in order to permit a study of changes in the rate of its growth or character. The voice in this woman is now somewhat more feminine than when first observed, and with the reappearance of normal, regular menstruation, the mental attitude is much improved. To say a cure has taken place, however, in any of these patients, we believe, has not been established.

In the experience at Baltimore, bilateral cortical hyperplasia often has presented certain characteristic clinical features in females, which differ from the tumor picture just described. Young and Howard have called attention to the fact that a curious anatomical anomaly is observed at birth, in the cases of cortical hyperplasia observed in the Hopkins Clinic. The phallus or clitoris is enlarged, and the urethra opens just below this organ, as in hypospadias, but without an external vaginal orifice. When the cystoscope is introduced into the vaginourethral sinus, the cervix may be viewed directly. The adult male characters in such patients vary in development. Evidences of virilism may appear as early as the second year; others seem normal in every way except for the congenital anomaly until the age of normal puberty, when male secondary sex characters appear. When these patients reach adult life they are usually small in stature and thick boned. Young and Howard have observed this syndrome due to cortical hyperplasia in two members of the same family twice in their series of ten cases. It has been reported only in females. Operative reduction of the mass of enlarged adrenal cortical tissue has not as yet produced an amelioration of symptoms in any of these cases.

No female patient should be operated upon for the possibility of cortical tumor resection without preliminary examination of the ovaries for the possible presence of a tumor such as arrhenoblastoma. This ovarian tumor may produce a picture of virilism clinically indistinguishable from that of a

suprarenal tumor, although more apt to develop during the active period of sexual life. Precocious puberty has also been reported to be associated with lesions near the floor of the third ventricle. The subject has been recently reviewed by Ford and is relatively very rare. Cortical adenomata have also been described associated with Graves' disease.

The relation of the syndrome just described to other tumors of the endocrine glands is awakening great interest, but no definite conclusions as to the underlying mechanism can yet be drawn. Particularly noteworthy are the similarities to Cushing's syndrome, or pituitary basophilism, to pineal tumors, to certain ovarian growths and to the so-called oat-cell tumor of the thymus, with secondary lung metastases. The clinical features of Cushing's syndrome, if not identical, certainly have many points in common with the adrenocortical syndrome, and hypertrophy or adenoma of the adrenals is frequently reported in such cases. It is after puberty that the pituitary basophilic and the adrenocortical syndrome closely approximate each other.

Differential points between the two conditions include the fact that the adrenogenital syndrome after puberty is generally confined to women, while the basophilic syndrome, although present usually in women, also occurs in men. The one is characterized by virilism, the other rather by depression and inhibition of sex function. It must also be stressed that cases of simple or of malignant cortical neoplasm may occur without evidence of the characteristic genitosuprarenal syndrome.

Crooke has recently reported a characteristic hyaline change in the basophil cells of the pituitary which he considers not to be an expression of cellular degeneration but rather of altered physiologic activity. It was found in 12 cases with the basophilic adenoma syndrome, associated not only with basophilic tumor, but also with thymus neoplasms, and neoplasms and hyperplasia of the adrenal cortex. The importance of this observation, if confirmed, obviously rests on the unitary basis which it suggests for the etiology of all of these diverse conditions. Differences in the hirsutism and in the form of obesity of adrenal, ovarian, and pituitary growths have been reported but are seldom of real differential diagnostic value. The pituitary has been associated

with the "girdle" type of obesity, the adrenal with the "buffalo" type, and ovarian obesity is described as generalized. Very few cases of the adrenogenital syndrome are described in the adult male, and I regard its actual occurrence as somewhat uncertain.

Excretion of large quantities of female sex hormone has been reported with negative pregnancy tests in a number of patients exhibiting the genito-suprarenal syndrome. The excretion of follicular hormone has been reported to disappear or diminish promptly from the urine following operative removal of the tumor growth. There are no abnormalities noted in prolan excretion. The excretion of large amounts of male sex hormone is also reported. Marrian has recently described a new phenanthrene compound present in the urine of these patients.

The injections of air in the perirenal fascial planes (Gerote's fascia) has been found valuable in outlining the tumor and the gland on subsequent x-ray. Often, however, it is disappointing. In operative removal of cortical tumors it is highly desirable to secure bilateral exposure of the organs in order to determine clearly the diseased side, and to be sure that a normal appearing adrenal is present on the opposite side. Such an operative procedure has recently been described by Hugh Young. This is a highly important matter, since atrophied adrenal tissue may be found on the side opposite the tumor. Severe postoperative shock is relatively common. X-ray therapy is of dubious usefulness, although it is known that tumors arising from tissue with the same anlage, as testis, are sometimes susceptible to radiation.

The curious association of lesions of the adrenals with various types of infections must be noted. Particularly is this true in association with epidemic cerebral meningitis, the Waterhouse-Fredriksen syndrome, or "adrenal apoplexy." The lesions often include massive adrenal hemorrhages, and other less striking lesions, particularly necroses. These may also occur in measles, scarlet fever, smallpox and typhoid, and frequently commence in the zona fasciculata. In meningitis they are usually associated with profound neurotoxic symptoms, and particularly with the development of a marked rash all over the body. Tillett has observed a group of cases recently at Balti-

more. It is not known whether recovery can take place from such adrenal lesions, as they are only recognized at autopsy.

The classic example of cortical hypofunction is thought to be Addison's disease. It is rare, the admission rate at the Mayo Clinic being about 16 per 100,000. There are two principal etiological factors involved. Tuberculosis has long been recognized as the most common. In such cases, a history is often obtained of lesions healed long before in other regions of the body, particularly in the lungs, genito-urinary tract or bones. If a reliable account of previous tuberculosis can be obtained from the patient, such an etiology in a given case may be assumed to be highly probable. Fibrocaseous tuberculosis is the most common type found in the adrenal glands. With the intensive study of the clinical picture of Addison's disease which has followed the use of the newer methods of diagnosis and treatment during the past six or seven years, the importance of atrophy involving a progressive necrosis with collapse of the stroma of the cortex has assumed importance. In most of the series recently described, atrophy has accounted for more cases than has tuberculosis. Ten of our fourteen fatal cases (Johns Hopkins Hospital) have showed atrophy at autopsy. Only four exhibited tuberculous lesions, although three others died at tuberculosis sanatoria, and autopsy reports were not available.

In our series, women are in the majority, although in other statistics the disease is much more common in males. Susman has recently remarked on the prevalence of atrophy cases among women between 35 and 45, and he suggests that some strain in connection with the sex functions, possibly the menopause, may be a significant factor in giving rise to cortical adrenal atrophy.

The diagnosis of Addison's disease due to tuberculosis by the demonstration of calcification of the adrenals and the use of the x-ray has been extensively used at the Mayo Clinic, where one-third of the cases were found to show calcification. Our experience has not been so satisfactory. One case in which calcification was so demonstrated during life, showed no trace of tuberculosis at autopsy, the adrenal lesions being solely due to atrophy.

The signs and symptoms of Addison's disease may be briefly recapitulated. Pigmentation is usually the first symptom to



appear in the milder cases and may persist for a long time before any other sign appears. It occurs especially in areas exposed either to light or pressure, and develops gradually. The history frequently given is that pigmentation is noted in the autumn and is attributed by the patient to a summer's tan which has failed to fade. All degrees of pigmentation may occur, and during periods of remission it may recede. The exposed parts of the body are usually most affected, and also those portions normally pigmented, such as over the nipples, under the axillæ, about the anus, the penis or outer margin of the labia. Pigmentation is not common in the vagina itself. Points of pressure, as under shoe fastenings, the line at the margin of a corset, under tight garters or where bandages have been applied, or vaccination scars frequently show increased pigmentation. A peculiar pigmentation on which we lay stress is frequently seen in the creases of the palms or about the knuckles or nail beds. Black freckles and deeply pigmented moles are frequently seen. Leukoderma, which was described by Addison, is commonly seen. I have never seen definite changes in the retina. Most significant is pigmentation of the lips and of the mucous membranes of the mouth in individuals in whom natural racial pigmentation may be excluded. Sometimes the pigmentation is very marked indeed. Only last week I saw a man of 46 with symptoms of but two months duration whose mouth presented as extensive pigmentation as is seen in the normal full-blooded negro. There is a very definite relation between the appearance and intensity of pigmentation and the severity and progress of the disease.

The second symptom is that of asthenia and muscular weakness, which may become profound and associated with various mental disturbances and fatigue. The mechanism of this phenomenon is not well understood but disturbances of carbohydrate metabolism, of the production of lactic acid, and of liver glycogen storage, as observed experimentally, no doubt also occur in the disease. Asthenia is markedly aggravated during the crises. It is greatly relieved by treatment.

The third characteristic symptom, namely, gastrointestinal disturbances, varies with the condition of the patient. These are always aggravated during the crises and may readily be confused with acute abdom-

inal disease. Loss of appetite is one of the earliest and most constant symptoms of increasing severity of the process, and increase in appetite is one of the surest signs of improvement. The weight should be closely watched. Anorexia varies from a general absence of appetite to an utter loathing and intolerance of all food. Vomiting occurs in all grades of severity, but even patients in relatively good condition will vomit occasionally. Constipation is the rule but attacks of diarrhea are common during the crises. Acute disturbances are nearly always associated with a lowered concentration of the plasma sodium and chloride, and when these are raised to their proper levels, the distressing symptoms sometimes disappear completely. Loss of weight is frequently striking but most patients are not actually emaciated. As a result of under-nutrition, menstrual disturbances may occur but usually they appear surprisingly late in the exacerbations of the disease, or crises, which are characterized by a marked aggravation of the gastric symptoms, fall in blood pressure and marked asthenia. Terminal rise in temperature usually occurs during the 24 to 48 hours before death.

The physiological basis of the Addisonian crises probably lies mainly in the disturbed mineral salt metabolism. Recent work has also indicated that an actual antagonism may exist between sodium and potassium in this condition, the urinary excretion of potassium being prevented while a marked renal loss of sodium occurs. The kidneys seem to lose salt because of abnormal functional permeability.

This mechanism of the crises makes it possible to utilize a diet low in sodium as a diagnostic measure. This is probably the most reliable procedure at present available for demonstrating the actual presence of Addison's disease. It should not be utilized, however, if it is possible to establish a satisfactory diagnosis otherwise, as it is a serious and somewhat dangerous undertaking. For the purpose, it is usually sufficient to place the patient on a diet of fruits, or fruit juices, together with milk and sugar. In a patient with the disease, this simple régime will result in the production of a crisis of greater or less severity within twenty-four to seventy-two hours. It should never be persisted in for a longer period of time than is needed to establish the diagnosis. Often a matter of a few hours only

will make serious difference in a therapeutic response. Weakness and distaste for food are the first symptoms complained of, usually with a fall in blood pressure. If nausea and vomiting occur, a grave condition is apt to supervene rapidly and the test must be stopped at once. A positive effect is associated with a drop in the concentration of serum or plasma sodium.

The treatment of Addison's disease involves the use of ample quantities of sodium salts and of a potent preparation of the cortical hormone. It is necessary to prescribe a definite daily quantity of salt no matter how well the patient may feel. To instruct him to take a well salted diet is not enough. If capsules are given, care must be taken that they are really absorbed.

The adrenal cortical hormone was prepared in a mildly active aqueous solution by Rogoff and Stewart and by Hartman in 1927. A potent extract was prepared by Swingle and Pfiffner in 1927, utilizing procedures which had successfully been used in the chemical extraction of estrogenic substances. Beef glands are generally used for the manufacture of this hormone although it has been claimed that other types such as pork have a higher concentration.

Parenteral methods of administration have hitherto been the only ones certainly effective. Oral preparations, including a charcoal absorbate of Grollman which is effective on adrenalectomized rats, have been used from time to time, but in our experience it is disappointing in the treatment of severe Addison's disease. Other methods, as with the use of a glycerol ex-

tract, may be useful in milder cases, and the charcoal absorbate, by mouth, may be useful in such cases. The recent demonstration of the chemical nature of the cortical hormone makes it highly likely, as with certain of the sex hormones, that oral administration, to a degree, at least, should be therapeutically effective.

The effective dose of the cortical hormone depends on the strength of the preparation and the severity of the symptoms. Our method is to use it as a supplement to salt only where needed, in dosage of 1 to 5 c.c. daily. Abscesses must be watched for, and infection and fever may precipitate a crisis. Recently the use of a diet low in potassium has also been advocated by Wilder and his group. Our experience has not indicated its great value. It is not an easy diet where food aversion occurs anyway. Gland transplantation has been disappointing. The use of adrenalin, as in the so-called Muirhead treatment, has been abandoned.

All in all, the increase in knowledge of the adrenals has been very rapid in the past six or seven years and if further progress occurs we shall, within the near future, I am convinced, see very remarkable improvements in our therapeutic resources and in our ability to cope with these interesting but distressing clinical conditions. It is particularly tempting to hope that with a further understanding of the relationship of the adrenal to salt and water metabolism, and to the pituitary, that an effective aid to the treatment of shock may become available.

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The plagues that once swept the world have been very largely eliminated. Every generation shows that they have given to mankind a longer span of life. Man is healthier and happier because of the mighty legionnaires of medicine.

So, to you, the Guardians of Life:—Your profession is on the threshold of vast new discoveries that will revolutionize life on this earth. For you alone remains the romance of great adventure.

No matter how far you go into this new-found continent of science yet always there is a golden chain that binds you to us. It is a magic chain. If it is ever broken your quest for the golden fleece of knowledge will be in vain. The links of that bind-

ing force are your human contacts. Though you walk with kings you cannot lose the common touch. Still the greatest joy of your tasks will be to soothe a fevered brow and to bring into world-weary eyes the light of hope.

In this new, strangely complicated civilization into which we are rushing today, to you is dedicated the great task of not only keeping Man alive, but, more:—keeping alive Man's faith in himself.

No man, no profession, has any higher call to duty: "For of the most High cometh healing."—From the Medical Supplement of the *Detroit Free Press*, September 26, 1937. Reproduced here by permission.



# CERTAIN READING DISABILITIES AS RELATED TO SPEECH\*

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The difficulty encountered by many children of normal intelligence in learning to read and write has commanded the attention of several groups in our social system. Primarily, of course, the parents may be acutely distressed when confronted by such a situation. Secondly concerned are those connected with fields of education, psychology, and neuropsychiatry. A study of the problem of reading difficulties is interesting to the neurologist in that it is closely associated with the whole question of the integration and disintegration of speech.

In 1928 Orton<sup>4</sup> brought out an interesting paper dealing with reversals in writing and reading as well as mirror writing and the ability to mirror read. His excellent contribution gave rise to considerable discussion, as well as some confusion, in the minds of his readers.

He referred particularly to a specific reading and writing disability occurring in children of average or above average intelligence. Specifically, he states:

"Certain features which seemed to be common to the group were: (1) difficulty in differentiating p and q and b and d; (2) a striking tendency to confuse pallindromic words like saw and was, not and ton, and to reverse paired letters and even whole syllables or words in reading so that they were read from right to left instead of left to right; (3) a considerable degree of capacity to read from a mirror—one boy actually read faster and with less mistakes with a mirror than without, and (4) a greater facility in producing mirror writing, i.e., in writing to the left with complete antitropic reversal of all letters."

In searching for an explanation of these particular difficulties, Orton brings out the theory of cerebral dominance and also that of visual levels. Before proceeding with our discussion, it will be necessary to quote him in full, particularly as regards the function and location of the visual levels and their relation to the term cerebral dominance.

"The first level serves to give awareness that a visual sensation comes from without and is not a recalled memory of things seen; in psychologic terms, this level furnishes the element of external awareness in sensation. This function, without much question, resides in the area striata or calcarine cortex of the occipital lobes. The second level, that of objective memories, serves as the storehouse for visual impressions of objects which have been seen. This function probably resides in the second type of occipital cortex which surrounds the calcarine or striate area. Up to this point the two hemispheres of the brain apparently work in unison to produce a single conscious impression; i.e., the messages relayed from the eyes to the two sides of the brain are fused so as to give only one impression. This is brought into relief by the fact that neither of these

functions is entirely lost as a result of the destruction of either hemisphere; a bilateral lesion is required to suppress the function of either the first or the second visual platforms. At the third or associative level, however, destruction in one hemisphere may result in complete loss of the associative function, resulting in inability to read (acquired word blindness), while destruction of exactly the same area in the opposite hemisphere will not give rise to any symptoms whatever. That hemisphere in which destruction produces loss of the associative function is called the dominant hemisphere, and may be either the left or the right, according to the side which habitually initiates the motor responses of the individual. *In other words, it is obvious that the visual records of one side only are used in symbolic association and those of the other are elided or inactive in this process.*"

"Structurally, however, there is no such contrast between the two hemispheres. The nondominant associative area is as well developed in size and complexity as is the dominant, and current neurologic belief (neurobiotaxis) would imply that this silent or inactive area must have been irradiated equally with the active to produce an equal growth. Such an irradiation, moreover, would presumably leave behind it some record in the cells of the nondominant side which one may call an engram. The engram in the nondominant side would be opposite in sign, however, from that of the dominant; i.e., it would form a mirrored or antitropic pattern. Under usual circumstances only one of these reciprocally paired engrams operates in association with the concept in reading, as is shown by the facts of acquired word blindness already cited, *and its antitropic or mirrored mate is elided or remains inoperative.* If, however, the physiologic habit of complete elision of these engrams of the nondominant hemisphere were not established, their persistence might readily serve to explain the failure to differentiate between p and q and between was and saw, and also to account for facility in mirror reading and mirror writing, and thus to explain those confusions of direction which have been extensively recorded in the literature and which as here described seemed to characterize all the cases of my own series. Since this conception of the disability as a physiologic variant differs so widely from the pathologic moment known to result in acquired word blindness, I have felt that the use of the term congenital word blindness was misleading and have offered the term strephosymbolia—twisted symbols—to demarcate better the series of cases showing this typical symptomatology."

When Orton postulated the idea of cerebral dominance in speech and its relation to particular reading difficulties, as mentioned above, and also when he conceived the idea of the three visual levels, he opened up the avenues for discussion of a perplexing and

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significant problem in speech integration as well as disintegration. One notes that the first level is one of visual awareness while the second level, "that of objective memories serves as the storehouse for visual impression of objects which have been seen."

In a discussion of the first level, we are immediately confronted by the psychological problem of "pure sensation" as related to meaning. Can one have memory of the visual impression of objects without realizing the meaning, at least to a certain extent, of the object? In other words, can there be such a thing as visual awareness without it being part of a perception? Must not other sensory and motor impressions enter into the picture as one realizes that he is dealing for the first time with something new? For instance, in acquiring the perception of an object such as an orange, vision, smell, taste, and touch all enter into its formation. Awareness is bound up in the definition of perception or knowing. It is difficult to conceive of being aware of anything new without its having some relation to our total behavior pattern. Vision alone would not suffice, and moreover it is a debatable question as to whether memory is the function of a localized part of the brain. Association enters into all brain function. For instance, in acquiring a perception of something new or foreign to our previous visual perception, one must necessarily use certain muscles, not only of the eye but of the rest of the body. In so doing, there is laid down motor imagery or, in other words, kinesthetic sensation. This motor imagery is coupled with the visual sensation and, in our opinion, cannot be separated from it.

As to the third visual level (symbolic level) and the difference in the engrams of the two halves of the brain and their relations to the reversals in reading and writing, there is room for considerable difference of opinion. In the first place, it is admitted that in the first and second visual levels the "two halves of the brain apparently work in unison to produce a single conscious impression: i.e., the messages relayed from the eyes to the two sides of the brain are fused so as to give only one impression." With that we agree and we are of the opinion that in the so-called third visual level, that level in which a symbol represents an object, the same mechanism takes place. We believe that the visual engram on the "dominant" side is the same as that on the

"nondominant" side and that there is no more reason for a reversal in visual memory of symbols than there would be in reversal of visual memory of objects. If, for instance, there were curved lines or scroll work on an object such as a chair, the visual engrams in the dominant and nondominant sides of the brain would be mirror patterns of each other and therefore could not fuse as is claimed for this level (visual memory of objects). Moreover in mirror writing where a reversed visual engram is presented, the child may and usually does write the mirror image never having seen it before. If we consider the visual engram only, how can one produce a reversed visual image never having seen it before? To that query, one might counter by asking still another question: How is it possible for the child so afflicted to read mirror writing which he never has seen before, faster than he can read normal writing? We will attempt an explanation not only of the last question but of the problem of reversals as a whole.

In the first place, it is well to mention that reversals in reading and writing occur principally in the left-handed child and according to Monroe are more common in the left-handed child who uses the right eye as the fixing eye than in the left-handed child who uses the left eye as the fixing eye. In the second place, we consider the problem to be principally a motor one, but not entirely so as will be brought out by further discussion. The work of Coghill<sup>1</sup> on amblystoma and his association of that work with the theories of the Gestalt school of psychology has an important bearing in our interpretation of the problem. He says: "The Gestalt school of psychology stands for total unity as the dominant principle governing mental processes. It seems, however, to have been concerned wholly with the processes that condition behavior, and to have entirely neglected the processes which determine the form of the behavior pattern. According to "Gestalt," a simple, pure or elementary sensation does not exist as such. There are no such units which combine to form perceptions. The perception is a "quality upon a ground": a total unity from the first. The apparently particular elements in consciousness emerge from a general field and exist only in relation to that field. This is equivalent, in the motor phase of the organism, to a totally integrated pattern in which par-



tial patterns become more or less individuated.

"This principle is thoroughly demonstrated for *Amblystoma*, a typical vertebrate, and there is nothing in our knowledge of the development of behavior to indicate that the principle does not prevail universally in vertebrates, including man. There is no direct evidence for the hypothesis that behavior, in so far as the form of the pattern is concerned, is simply a combination or coördination of reflexes. On the contrary, there is conclusive evidence of a dominant organic unity from the beginning. That evidence appears not only in the manner in which behavior develops, but particularly in the manner in which the nervous system puts the principle into effect, for, as shown in the first lecture, the nervous system concerns itself first with the maintenance of the integrity of the individual, and only later makes provision for local reflexes." For instance, he explains that "the first limb movement is an integral part of the total reaction of the animal and that it is only later that the limb acquires an individuality of its own in behavior. The local reflex of the arm is not a primary or elementary behavior pattern of the limb. It is secondary and derived from the total pattern by a process of individuation. In the further development of the behavior pattern of the arm, the same principle is observed: The first elbow flexion occurs with action of the arm as a whole, and the forearm only later acquires the independence of a local reflex. *So also is it with the movement of the hands and the digits.*"

Herrick,<sup>3</sup> in his comprehensive studies on comparative anatomy and physiology, expresses much the same idea when he states:

"In the course of this evolution we can follow the transition from the simplest sort of *mass-action* to very complex reflex and instinctive patterns and from the latter to control of behavior by individually learned and cortically directed analysis of experience, which culminates in the fabrication of conscious symbols and rational control. On the structural side we see a gradual transfer of the center of physiological dominance and integration from the midbrain to the striothalamic complex and, in the third stage, to the cerebral cortex parallel with the shift from physiological conditioning to intelligently directed motivation."

The evolutionary significance of some of our simple body movements would seem to fit in with the above theory. We will consider, for instance, one individual set of movements, such as the spreading of the fingers of the right hand, a movement which may have been connected with swimming. One can readily see that such a voluntary movement executed with any degree of accuracy would necessarily come later in our development than voluntary movement of the extremity as a whole. The similar set of spreading movements of the left hand is developed at the same time, particularly when regarded with coördinated acts such as swimming. On analysis, we notice that these movements of not only the fingers of the two hands but the arms in swimming movements are mirror images of each other.

They are much more easily executed than if one attempts to adduct the fingers of one hand while spreading or abducting those of the other. Whatever highly individuated reflex motor patterns are acquired by one side of the body, their mirror patterns are acquired by the opposite half of the body, but not to the same degree of accuracy in their execution. These engrams, or patterns, although called motor are in a sense sensory or more accurately sensory-motor in that we record in our mind a memory of the movement. This is kinesthetic sensation or motor imagery. The same motor imagery or kinesthetic sense is involved in such a highly complicated act as writing. It has been observed previously<sup>2</sup> that the average right-handed person is able to write mirror writing with the left hand when, simultaneously, he is writing with the right hand and in the opposite direction; that is, from left to right. However, in so doing the mind must be kept on the writing which is being carried out by the right hand and the left hand be allowed to simply follow along and assume its own course. The writer has noted that a left-handed individual who has been trained to write right-handed does not make this mirror pattern when writing with the pencil both in the right and the left hands. The same reflex mechanism occurs in making loops or circles when using, simultaneously, one pencil in the right hand and another in the left; that is if the direction of movement with the right hand is clockwise that with the left hand is counter-clockwise. In the process of acquiring integration of this clockwise movement with the right hand, the eyes in conjugate movement rotate in clockwise manner. We have observed that the right-handed person can rotate the eyes clockwise much faster and in better coördination than in the opposite direction. Rotating them in the opposite direction is comparable to a right-handed person attempting a left-handed movement.

If it so happens that in the right-handed person the left eye is the fixing eye or in the left-handed person the right eye is the fixing eye, one naturally would expect that the head would be inclined to turn toward the side of the handedness. This asymmetry of handedness and eyedness adds much to the confusion in the child's mind as to the acquiring proper direction of movement in both reading and writing in



that it has a tendency to disrupt the total pattern acquired previously.

If one has difficulty in acquiring the proper direction of movement in learning to write and read, is it not reasonable to assume that he has the same confusion or difficulty in acquiring visual perception of an object? The eye movements take part in the process of acquiring that visual perception, and it is quite possible that when one first perceives an object, the conjugate eye movement is from right to left in a left-handed individual. This right to left movement is undoubtedly accentuated in the left-eyed person. Thus, when a child of this type is first presented mirror writing for inspection, the conjugate eye movement used is from right to left, and there is an immediate association with the motor imagery, which already has been laid down as a part of the total pattern when he was learning to write with the right hand. Thus the reason for reading mirror writing faster than normal writing is explained. The engrams are visuo-motor and the body movements of the whole left side form the dominant pattern, but one must not lose sight of the fact that they are a part of the total pattern.

One often notices the left-handed person write with the hand in what can best be described as an "upside down" position (acute flexion of the hand on the wrist), with the point of the pen facing the writer. If one stops to analyze that movement, he will find that although the pen moves from left to right, the hand movement itself with relation to the rest of the body is a right to left movement.

In certain cases of aphasia, one may encounter directional confusion not only in reading, writing, and spelling, but also in arithmetic. This was admirably demonstrated in a case reported by Singer and Low.<sup>6</sup> We have been interested in a case which has, in our mind, an important bearing on the problem.

Mr. T. D., an accountant of forty-eight years of age, suffered a severe cerebral concussion a year and a half previous to his first visit to my office in August, 1932. At that time, he still complained of difficulty with his vision, a certain amount of headache and dizziness, and inability to calculate with any degree of accuracy. He also had noticed that he was occasionally writing "was" for "saw" and vice versa. He made numerous mistakes in typing, almost all of which he was unaware. As a child the patient was distinctly left-handed, but he had been forced to learn writing with the right hand.

The eye consultant reported the following: "Vision, 6—6 in each eye. This is slightly worse than

before. There is one degree of exophoria for distance, four for near. The abduction is five and the adduction is four. The fundus and tension of each eye are normal. The fields show a marked change, there being a left homonymous hemianopsia for both form and color. The remaining form field is considerably contracted in the right and greatly contracted in the left eye. The fields are not tubular and do not have the characteristics of either hysteria or malingering." Fields taken five months later were practically identical with the above. Central vision was preserved in either eye.

The defect in the visual fields would necessarily point to a lesion of the right optic tract posterior to the chiasm. And yet with the visual memories of the right occipital lobe not functioning, the patient presents the recent problem of reversals. This case would seem to point strongly to the fact that the difficulty is not primarily visual but kinesthetic.

There is still another interesting as well as perplexing situation as regards certain aspects of cases of so-called total aphasia. The lesion is usually confined to the "dominant" hemisphere and, as in a recent case of mine, resulted in a complete right hemiplegia, the left side being normal in all respects. The question is: "Why is there total aphasia and why should not the individual have retained speech up to the five year level, the time at which his handedness first began to function as regards reading, writing, and spelling?" One would surmise, without being definite by any means, that even with the acquisition of the earliest perception of speech, *handedness and motor imagery involving all muscles of speech* had entered into this physiological and psychological problem. Further, if the handedness as a factor in the motor imagery is interfered with by the paralysis, speech is destroyed as far as the earliest levels. The total pattern of the five-year level has been disrupted.

Another interesting phase of this whole problem is the possibility of an hereditary basis in connection with handedness. Monroe states that according to her tests, about eleven per cent of children in one group were left-handed. This left-handedness persists regardless of the fact that they are living in a right-handed world. Suppose the conditions were reversed. We should then undoubtedly find that the same percentage (eleven) were right-handed. We have then the two extremes, of left- and right-handed individuals, whose adaptability is such that they would remain right- or left-handed regardless of the handedness in their



environment. Together they constitute from twenty-two to twenty-five per cent, while the group in between the two extremes with balanced body symmetry constitutes seventy-five to seventy-eight per cent. The latter group becomes right-handed in a right-handed world, or would become left-handed in a left-handed world. Then, according to all the laws of probability and chance, there are at birth as many left-handed people as right-handed people, and the three to one ratio exists only as regard body synergy and asynergy.

This theory would account for the adaptability of the Semitic race, who were at one time supposed to be left-handed (Critchley) and to have written from right to left, while at present the opposite is true. It does not seem probable that if cerebral dominance were the initial factor in the question of handedness and its allied problems, the handedness of a race or any part of it would change so completely from one type to another. That does not happen, in our opinion, according to laws of heredity.

However, according to the theory which we have postulated above, a change of handedness and direction of writing could easily take place because seventy-eight per cent or thereabouts are in perfect body balance or in a condition of perfect synergy as regards the two halves of the body at birth.

What, then, is the practical application of the whole question as regards the parent and teacher? And what steps should be taken to aid in alleviating the situation? We offer the following suggestions, almost all of which are in agreement with those as noted by Orton.<sup>5</sup>

First, the handedness and eyedness of the child should be determined as nearly as possible by the kindergarten teacher.

Second, psychological tests should be given for visual and auditory memory, and for the defects in association between the two.

Third, if there is confusion as to the handedness, it would be well to encourage the child to use the hand on the same side as is the fixing eye. In this way, one encourages the development of reading, writing, and arithmetic as evolving from the total pattern.

Fourth, in the teaching of writing to the left-handed child, allow the paper to be placed at the left upper corner of the desk, and allow and even encourage the child to

write backhand. The teacher, in marking such a child in writing, should not compare his work with a right-handed standard, but with a good backhanded slant.

Many of these children acquire ideas of inferiority through their inability to conform to a right-handed pattern.

Fifth, the left-handed child who is having difficulty in reading, writing, or spelling, should be given an opportunity to read aloud and to use a pointer as in reading at the blackboard. If there is extreme difficulty, allow him to use the forefinger of the left hand in reading from his book. In that way all of these motor movements, such as tongue, lips, and finger, which grow out of his total pattern, aid him in establishing the proper direction (left to right).

Sixth, inasmuch as this type of case is apt to have confusion in the visual patterns on account of confusion in direction, it is well to stress the phonic method of teaching early in their school career. They should learn the alphabet and fundamental syllables, and learn to build up words from the fewer number of symbols than the visual-minded child who is also right-handed, and in whom the patterns fit with his previous total pattern.

Seventh, on account of the asymmetry of the pattern in the left-handed child who is constantly forced to move in a different direction from that which is normal to him, he is apt to show disturbances in rhythm, so that early in his speech training he should be taught simple rhymes, poetry, and music. Few of us realize the rhythm expressed in the eye movements in our ordinary silent reading.

Very little provision has been made in the average school class room for the left-handed child, when one considers the awkward and even fatiguing position the left-handed child must assume in using a seat or recitation arm rest that is built entirely for the accommodation of the right-handed child. All that is necessary for us who are right-handed to realize this is to imagine the inkwell and arm-piece in the recitation room placed on the left side.

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## NEUROSYPHILIS—THE IMPORTANCE OF EARLY DIAGNOSIS AND NECESSITY OF SPECIALIZED THERAPY\*

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We are all familiar with the tremendous effort that is being made to wipe out syphilis in the United States. This concerted attack on "Public Enemy Number One" among the dread diseases affecting human life is a great step forward in the betterment of mankind. However, stamping out or preventing the development of new infections is not enough. Our institutions for the blind and insane will continue overcrowded for many years to come unless a more specific effort is made by the Medical Profession to recognize and properly treat early neurosyphilis. One might almost refer to the neurosyphilitic as the "forgotten man" in the treatment of syphilis. To my mind, too great emphasis is placed on blood serology and routine mass treatment, and far too little importance attached to the spinal fluid examination.

According to a recent report compiled by the Coöperative Clinic Group,<sup>1</sup> nervous system involvement was present in 53.4 per cent of the cases in which spinal fluid examinations were done. The Mayo Clinic<sup>5</sup> reports, on repeated surveys, that 65 to 78 per cent of the syphilis seen there had a neurosyphilitic aspect. Nervous system involvement, therefore, must be recognized as a potentiality in every case of syphilis, and, since the spinal fluid examination is the only positive diagnostic procedure, it seems inconceivable that such a simple, precautionary method is so often neglected.

I know of no satisfactory routine method of treating syphilis. Each case presents its individual problem and requires individual treatment. Proper treatment procedures, then, lie solely within the discretion of the attending physician. Unfortunately, the use of fever therapy has been almost entirely confined to institutional practice and the hyperpyrexia machine is not available to many physicians, especially those in the smaller communities. Routine mass treatment, consisting of continuous injections of arsenicals and heavy metals, unquestionably will reduce the incident of neurosyphilis, but far too many nervous system involvements develop under this mode of treatment to allow us to assume it is adequate in arresting this phase of the disease. The arsphenamines and heavy metals do not permeate the nervous tissue in sufficient

quantity to effectually cope with neuro infection due to the hemato-encephalic barrier, making supplementary and special therapy procedures mandatory. I believe it is an accepted fact that the use of fever therapy is imperative in the treatment of paresis and taboparesis. Authorities differ as to the comparative merits of hyperpyrexia induced by external methods and heat produced within the body. The shortage of hyperpyrexia machines and the cost to the patient may be the determining factors in many instances. Fortunately fever therapy, produced by malaria or typhoid vaccine, is available to all at a comparatively low cost. Citrated malarial blood, which will remain infectious at almost any temperature for at least 48 hours, can be procured from almost any public medical center.

The favorable results and apparent clinical arrest of nervous tissue deterioration by the use of fever therapy in asymptomatic neurosyphilis, where this diagnosis is made by spinal fluid examination, range with different observers from 95 to 100 per cent. Wile and Hand<sup>6</sup> report arrestment in 95.7 per cent of cases. Moore,<sup>3</sup> in his "Modern Treatment of Syphilis," reports complete remissions in 30 to 40 per cent of paretics treated with fever therapy, but only 3 to 5 per cent complete remissions where routine arsphenamine and heavy metals were used. These figures certainly argue convincingly in favor of fever therapy.

With the induction of malaria, the question of possible danger to the patient naturally arises. Here, again, the importance of early recognition of neuro involvement should be emphasized. Certainly better therapeutic results may be expected and the risk to the patient minimized if the treatment is begun early in the course of the disease,

\*Chairman's Address given before the Section on Dermatology and Syphilology, Michigan State Medical Society, September 28, 1937.



before extensive tissue damage has occurred. Then, too, induced malaria is easily controlled, differing from the natural disease in its great susceptibility to quinine.

Typhoid vaccine, though not as extensively used, certainly has a definite place in neurosyphilitic therapy, especially in certain cases where malaria is contra-indicated. Typhoid vaccine, being much easier to obtain, can be used in isolated communities where the use of malaria is not feasible, and in cases proving immune to malaria. The mortality rate is exceedingly low in this method of treatment and authorities such as Kulchar and Anderson<sup>2</sup> contend that it compares favorably with other forms of fever therapy.

Touching briefly on intraspinal therapy, I believe its value in the treatment of syphilis is a debatable question among syphilologists. However, I am of the opinion that medical science has not as yet developed an adequate substitute for intraspinal therapy in the treatment of primary optic atrophy and tabes dorsalis. Moore,<sup>3</sup> together with other notable authorities, reports an improvement or arrestment in more than 50

per cent of primary optic atrophy treated by intraspinal therapy. Considering the excellent results obtained from its use, and considering the fact that optic atrophy results almost invariably in complete blindness under routine arsphenamine and heavy metals, it would seem that the merits of intraspinal therapy must be acknowledged.

I have made no attempt here to go into detail regarding treatment procedures, and have purposely omitted mention of tryparamide and other therapeutic measures because the purpose of this paper is simply to emphasize the crying need of an early diagnosis and the use of specialized therapy in the treatment of neurosyphilis.

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## EDUCATION IN MATERNITY ESSENTIAL TO PUBLIC HEALTH

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It was in 1912 that the first Bureau of Child Hygiene was established in a city health department in this country as a permanent part of that administrative branch of civil government, and in 1914 the first such bureau was developed in a state department of health.

Dr. Josephine Baker, the director of the Bureau of Child Hygiene in New York City, created as a major activity for the protection of infancy and childhood the Little Mothers' Leagues in the high schools of that city, through which even more than by the baby stations was the process of education of mothers in the care of their children successfully promoted.

Progress in the breadth, depth and quality of education for the saving of infant lives has been continuous and effective in the past quarter century until we now enjoy throughout the nation lower infant mortality rates than have prevailed at any time in human history among so large a population under one government and including such a variety of race stocks, economic and occupational conditions, distributed so widely in geography and climate.

From concern exclusively with the survival of the babe at least through its first year of life and with the diarrhea and en-

teritis which was the chief hazard to its life, the scope as well as the name of the bureaus or divisions of health departments serving this constantly expanding and perhaps most important of all the fields of public health, has been broadened to include every stage of the human reproductive cycle from the conception of the new life to the achievement of bodily and mental maturity.

We now have as a declared and established standard function of local, city or rural, state or provincial and national or federal health services in most modern na-

tions that of the bureau or division of maternity, infancy and child hygiene.

To such an audience as this it is quite unnecessary to recall to your attention or to review the subdivisions of this field in any detail, noting only that there are services to be rendered, preferably by the private practitioner of medicine in his intimate personal relation to the individual and the family for the guidance of the expectant mother, the protection of the infant, the periodic supervision of the runabout or pre-school child, the health management of the life of the child while it is still subject to the compulsory education laws and until it is free to enter industry and self-support, at approximately the age of maturity or a few years before.

What more could be asked of public health authorities than to promote through public information, to develop by educational methods, to supplement by services for those unable to meet the cost of private medical guidance in health, the comprehensive range of professional activities of the practising physicians of the community on behalf of the survival, the integrity and vigorous health of the family, which is, after all, the basic unit of our modern society and never more precious or essential than now to a continuity and progress of our civilization?

This is the sort of challenge which rises to face the health officer and the community he serves, whenever he begins to feel satisfied or complacent with his health program and its progress.

We might as well admit that we shall never achieve an end point, a perfection of endeavor for health, as long as the curiosity and resourcefulness of the human mind continues to discover new biological facts and improvements in their application.

While new knowledge is often disturbing, generally criticized, and usually uncertain in the results it leads to, it must be accepted as an axiom among sanitarians and practitioners of preventive medicine that whatever is true and affects favorably the quality, quantity, creation or survival of human life is worthy of study and practice.

The reasons for our present discussion are that the embryologists, comparative anatomists, general biologists, chemists, sociologists, statisticians, as well as psychiatrists, obstetricians, gynecologists and pediatricians among the specialists of medicine have made

new observations and developed new facts and technics which have disturbed the traditional patterns of contemporary thought, and social usage, and have challenged the medical profession, legislators, the courts and society itself to take action consistent with the facts, lest damage develop to the most precious values of human relationships, and a hazard to national and cultural survival become acute.

Facing facts always calls for courage, and one way of measuring mental and emotional maturity and health, whether individual or social, is the manner in which persons, the family and the community face new facts and alter their conduct and attitudes according to the evidence and ethics of the situation.

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And now, I see from your faces that you wonder what this glimpse into well-known history, and the repetition of philosophical generalities have to do with the practice of public health in Michigan or with the interests of the Maternal Health League of this state.

Just this, that in the past few decades it has become obvious from a great mass of detailed and corroborated information, coming from the several fields of science already referred to, that further protection of women in both the unmarried and married state against unsuitable, undesired or unsafe pregnancy requires a variety and quality of information not universally available to men and women under competent or responsible authority.

Furthermore, that many of those intending marriage are crudely ignorant of the mutual biological and psychological obligations, hazards and opportunities of the married state, and that such ignorance commonly leads to much marital misfortune and is one of the factors leading to divorce which occurs in one of every six marriages in the United States and to the prevalence of abortions undertaken for other than distinctly pathological conditions in the mother, and carried out under conditions which lead to an enormous loss of maternal life. About one quarter of all maternal mortality follows abortions. About one half of all abortions are illegal or criminal. There is about one abortion for every two or three pregnancies. More than half of the women who have borne children have had one or more abortions. Ten per cent of all abortions are



in unmarried women. The five major external factors leading to abortion are, economic distress, occupational necessities, illegitimacy, domestic relations, and fear of confinement.

However, probably more important than either the protection of the body of the married woman against uncontrollable conception, or the hazard to the mother of artificial interruption of pregnancy, is the potential benefit to offspring from understanding by the parents of the biology of conception and the principles of marital hygiene. It would appear obvious that such knowledge as is in the possession of mankind bearing upon the quality of inherited characteristics and upon the encouragement of superior, and the gradual diminution of inferior, elements in human stock, can be applied chiefly although not exclusively through the education of young men and women prior to and during married life in the years of potential productivity.

With a falling birth rate throughout all occidental nations, and a selective and relative infertility of those elements of our population from which the best quality of human stock should be expected, there are good theoretical and practical reasons for providing under official and approved voluntary auspices such sources of information as will tend to contribute to racial improvement, and to counteract by encouragement of childbearing among the fit and competent the present deteriorating effect of unconsidered procreation among those least able to create offspring and rear them in health.

Specifically, it appears to be necessary and timely for official health agencies of state and local government to add to the existing functions of their bureaus of maternity and child hygiene that of marriage advice and of counselling in the interest not only of a eugenic effect upon the next generation but as a very immediate and practical means of reducing maternal and neonatal mortality.

The question of legality of advising on contraception was settled by the decision of the Federal Circuit Court of Appeals for the Second Circuit, in December, 1936, in the case of *United States vs. One Package*, parts of which I quote:

"It is true that in 1873, when the Comstock Act was passed, information now available as to the evils resulting in many cases from conception was most limited, and accordingly it is argued that the language pro-

hibiting the sale and mailing of contraceptives should be taken literally, and that Congress intended to bar the use of such articles completely . . . yet we are satisfied that this statute . . . embraced only such articles as Congress would have denounced as immoral if it had understood all the conditions under which they were to be used.

"Its design, in our opinion, was not to prevent the importation, sale or carriage by mail of things which might intelligently be employed by conscientious and competent physicians for the purpose of saving life, or promoting the well-being of their patients. . . . The policy of Congress has been to forbid the use of contraceptives if the only purpose of using them be to prevent conception in cases where it would not be injurious to the welfare of the patient or her offspring; it is going far beyond such policy to hold that abortions, which destroy incipient life, may be allowed in proper cases, and yet that no measures may be taken to prevent conception even though a likely result should be to require the termination of pregnancy by means of an operation. It seems unreasonable to suppose that the national scheme of legislation would involve such inconsistencies and should require the complete suppression of articles, the use of which, in many cases, is advocated by such a weight of authority in the medical world."

Health officers, therefore, under this decision, should not be legally hampered in adding contraceptive service to the existing functions of their Bureaus, unless, as in the case of Massachusetts, state laws constitute a barrier which, in Michigan, is not the case.

As has occurred in so many of the fields of public health, private initiative and resource, the vision of individuals, and the social concern of groups of like-minded and public-spirited citizens, have preceded the necessarily more slowly moving and conservative action of agencies of civil government. Practically all the innovations in the field of maternity and child hygiene, of visiting and public health nursing, of the practice of preventive medicine in tuberculosis, syphilis, gonorrhea and industrial hygiene, now all included in the programs of health departments, were proposed, tested in practice, found to be effective and promoted to the public by non-official agencies before they were accepted as necessary by health departments, or tax monies were provided for their operation.

It is now almost ten years since the Ministry of Health of Great Britain permitted, and five years since it formally endorsed, the inclusion of contraceptive advice and marriage counselling among the duties of local maternity centers by physicians competent in gynecology. For much longer periods have these functions been served in some other European countries by government, through health and school officers and by authorized activities of churches of all denominations, and by non-official or voluntary associations with interests similar to those of the Maternal Health League of Michigan.

In the United States today there are in operation not less than 311 consultation centers under voluntary auspices, 123 supported in part or wholly by public funds, and of this number 39 are in city or county health departments where some or all of the educational and technical services are now offered and availed of within the law to a constantly increasing extent. Of the total of 434 such centers in forty-two states of the United States, 353 are medically directed.

In addition to these centers, which are primarily for contraceptive advice, during the last few years an increasing number of marriage advice and consultation bureaus has been set up.

Among these are four in New York, three in California, two in Ohio, and one each in Illinois, New Jersey, Pennsylvania, Michigan, and Massachusetts. In each of these bureaus people who have studied the problems of marriage and are competent to give helpful advice, act as consultants.

While I am of the personal opinion that the kind of information which is needed and the character of consultation called for should under ideal social and professional relationships be provided in the normal activities of the family physician at his office or in his patients' homes, I recognize the fact that medical and social education of physicians in the past has not prepared many of those now practicing to meet unaided the reasonable demands for information and guidance of those considering or actually entering upon marriage, and for this reason it seems to me essential that, with the cooperation of voluntary or governmental hospital out-patient departments or independently, but in any event with the close collaboration of the organized medical profes-

sion, and with the helpful assistance of the public health nurses and social workers of the community, each full time unit of local public health administration provide itself, or encourage the establishment under private auspices of a consultation and advice service for men and women, married and unmarried, where information related to the function of reproduction, be made available for the purposes of reducing sickness and death among women and children.

This responsibility seems to me of a kind which must be accepted, if for no other reason, because misinformation of a mischievous and misleading character is now being commercially promoted for purposes of profit or immorality to the discredit of biology and the detriment of contemporary society. The best way to correct abuse born of secrecy, shame, fear and prudery is the responsible statement of facts to those capable of understanding them by persons legally authorized to practice medicine.

That this proposal is not merely the dream child of a moment of wishful and visionary thinking on my part can be understood from the fact that since 1931 I have been an officer of the National Committee on Maternal Health, and its predecessor the local committee, with its offices at the New York Academy of Medicine. Under the auspices of this committee have been carried on continuously through the past fourteen years medical and social research in the field of fertility and sterility as these bear upon maternal health, and most of the important professional contributions in this country to our present medical knowledge of contraception and the methods and results of the various methods of its application have been published under the auspices of this committee.

Furthermore, I venture to quote from two professional contributions I have offered elsewhere on this subject, one before the American Public Health Association in 1934, the other to the annual meeting of the American Eugenics Society as a report of a sub-committee of the Public Health Relations Committee of the New York Academy of Medicine in 1937.

In an address at Pasadena, in 1934, I ventured the following statements and have had no reason since then to alter them:

"Closely related to the problem of syphilis, which is primarily one for physicians, sanitarians, nurses, and educators to solve, is that of a health service for marriage advice, primarily in the social inter-



est of family security, but inseparable from medical, legal, and educational implications.

"From the early, much criticized, highly controversial, sometimes legally interdicted efforts to translate biological knowledge into common usage by married women and their husbands, through offices or clinics, as frankly contraceptive information, by persons of medical or less competent qualifications, there has been abroad and in the United States a steady growth in the understanding of the useful functions such agencies might serve, the social and educational and preventive medical concern they have for a mature society, and the auspices under which they may safely be operated."

"Since the origin of marriage counselling in 1922, under public control in Vienna, the German speaking countries of Europe have developed a total of 1,100 such centers, of which 900 are under private auspices. The first official bureau was opened in Berlin in 1926; Switzerland opened official marriage advice bureaus in Zurich in 1931 and Basle in 1933. Approximately three quarters of those who come for advice are concerned with problems of sterility, contraception, therapeutic abortion, and medical conditions contraindicating pregnancy; the majority of the remainder seeking information on questions of inheritable and congenital defects and disease, where mental abnormality, tuberculosis, and syphilis exist or are suspected in the family; and a substantial number are concerned with the physiology and pathology of sex adjustment, before and during wedlock. These stations are under some appropriate legally recognized religious, health, educational, or other professional auspices such as we are familiar with in the origin and promotion of prenatal, baby health, tuberculosis, and venereal disease clinics in this country."

"The greatest service of the agencies at present operating in the large and small cities of the United States, aside from their contribution to competent professional education in contraception, is that of preventive medicine in the fields of venereal disease and pelvic cancer."

"... For our needs at present in this country a physician, nurse and social worker especially prepared for such a responsibility will be required at each such station."

"Both mental hygiene and social hygiene, as these terms are used in our countries, should benefit by the official inclusion of a marriage advice service under the health department or in connection with the outpatient service of a general hospital."

"This innovation will require some social initiative, imagination and courage, in all of which it should be expected that the health officer should share or actually lead."

"Let us teach for the sake of women the knowledge which will permit them to choose the time and circumstances of their own childbearing."

If I were to express the objective to which I believe the more wide-spread availability of marriage counselling would contribute it would be about as follows:

"Let us set aside a fair portion of our determination to see to it that the babe is well born, into a world free for the exercise of his entire capacity for advance of his own and his fellows' lives, without sacrifice of the lives of others as a condition of his own survival."

Among the elements of a program for the practical application of eugenics I offered the following:

"It seems to me that no hindrance of tradition, re-

ligion, law or social fashion of conduct can long delay the progressive spread of a body of fact increasing in accuracy and practical usefulness and safety which will free women of most of the uncertain, accidental, and almost thoughtless occurrence of pregnancy.

"Only when the circumstances of a new life can be calculated, predetermined, chosen with forethought and planned for, and, per contra, undesired and undesirable creation of life can be with certainty and safety prevented, shall we have the essentials upon which to build a manner of family, the begetting and rearing of children, to satisfy the reasonable ambitions of those who would apply genetics for eugenic ends.

"All knowledge has carried hazards of misuse. Many a priceless fact has been exploited for selfish ends.

"However, curiosity is perhaps man's most precious attribute after his capacity of inhibition or self-control.

"The medical profession exercises, as it were, the trusteeship of society in all sciences and arts which may prevent disease, and make its occurrence more bearable, and less likely to shorten life. Society will do well to demand of medicine that it consecrate its treasury of resources and its good repute to the even broader and more enduring values of constructive guidance to better structure and function of man's body, to a more perfect life of thought, and emotion, conduct and social adaptability, and to the longest span of human life which is consistent with continuous use and happiness to the end."

Let me repeat my recommendation that official state, municipal and rural health departments where served by full time health officers in the State of Michigan include in their program of services the counselling of men and women in the hygiene of marriage and where necessary in the control of conception in the interest of the health of mother and children in the family.

If this objective cannot be achieved through tax supported official agencies the necessary services should be encouraged, when they are supplied by voluntary efforts acceptable to the medical profession.

Probably a greater reduction in the mortality of women from causes related to their reproductive function would result from general knowledge among married people of the safe and effective means of controlling conception than we can achieve by any other resource at our disposal.

An understanding coöperation among practicing physicians, local health officers, nurses and social workers is necessary in this as in other fields of maternal and child hygiene. These four groups concerned with preventive medicine should be able to carry out the simple educational effort required without offense to any of the good qualities of modern society and with definite benefit to the health of women and their children.



## SULFANILAMIDE IN UROLOGIC INFECTIONS\*

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In the brief span of three years since its introduction<sup>10</sup> probably no form of chemotherapy has attained such universal acclaim as sulfanilamide. It has been employed in an effort to combat infection of all types and in many cases with considerable degree of success. The mechanism of its action has been studied by several, including Colebrook and Kenney<sup>5</sup>; Long and Bliss.<sup>20</sup> The fact that it is excreted to a very marked degree in the urine in either its free or conjugated form has been demonstrated by Long and Bliss<sup>20</sup>; Marshall, Emerson, and Cutting<sup>21</sup>; Helmholz and Osterberg.<sup>15</sup>

While not proposed originally for use in the urologic field, it has nevertheless, as we are all aware, captured a leading position among our therapeutic weapons in infection of the uro-genital system.

R. D. Herrold<sup>16</sup> in February, 1937, observed that the urine obtained from a patient receiving sulfanilamide remained clear upon incubation and thereupon administered it to patients with infection of the upper urinary tract with surprisingly successful results in some cases wherein other recent therapeutic agents, including mandelic acid, had failed of such accomplishment. He<sup>17</sup> very kindly suggested it for our use upon the seventh of March with the view of evaluation as to its action in all types of urinary tract infection, including gonorrhea. We have since that date kept careful records of these patients more with the purpose of reaching our own conclusions rather than from that of subsequently reporting our findings.

The results of this study demonstrated to our satisfaction several facts which appear incontrovertible and all of which have without question previously been reported elsewhere from some special viewpoint. We have endeavored to correlate all the advantages and disadvantages as they have appeared in this group of cases. The vast majority of these were private patients of an ambulatory character though a few were hospitalized. This group may be said to fairly represent the type of case consulting the average private practitioner who does not have available institutional supervision or control.

We have endeavored to determine the efficiency of this new agent as compared with other forms of therapy as well as evaluate the reactions of the drug as to fre-

quency, character, and degree. This group of cases includes only those urinary tract infections uncomplicated by obstruction or those in which the obstruction has been relieved, and it is possible that the ultimate risk in the administration of the drug is definitely increased in the presence of obstruction, as pointed out by Marshall, Emerson, and Cutting<sup>21</sup> and R. D. Herrold,<sup>16</sup> the excretion being possibly delayed with impaired renal function, and one may raise the question that the physiologic saturation point of the body might be definitely elevated in such cases. Evidence that such is not the case, however, is advanced by Cook and Buchtel<sup>7</sup> in reporting two cases placed upon sulfanilamide treatment in whom the urea nitrogen exceeded one hundred milligrams per one hundred cubic centimeters without untoward result.

In all, two hundred and three cases with an additional eleven cases studied separately by one of us (J. F. Harrold) have been considered in this survey, additional cases having been discarded for lack of complete data. These cases were grouped as follows: Gonorrhea (male), eighty-five; gonorrhea (female), fourteen; urethral stricture, seven; non-specific urethritis, twenty-five; pyelitis (male), seven; pyelitis (female), forty-four; postoperative, twenty; renal tuberculosis, one.

It has been pointed out by many<sup>1,3,5,6,9,11,13,14,18,19</sup> that the use of this agent is not without danger and a careful record was kept of all patients under treatment from the point of view of determining the deleterious effect, if any, from the symptomatic reactions. These we find, as has been observed by almost all authors, were extremely varied and occurred to some degree in the surprising number of one hundred eight patients

\*Presented before the North Central Branch of the American Urological Association, October 23, 1937.



out of a total of two hundred three. In no case was symptomatic reaction suggested to the patient but all complaints were volunteered. A number of patients complained of several and varied symptoms and for the sake of discussion we have grouped these into four general headings: Gastro-Intestinal, Central Nervous System, Dermatoses, and Systemic.

TABLE I. REACTIONS

Gastro-Intestinal:	
Anorexia .....	6
Nausea .....	32
Vomiting .....	3
Diarrhea .....	1
Total .....	42
Central Nervous System:	
Headache .....	8
Vertigo .....	14
Tinnitus .....	0
"Nervousness" .....	8
Paresthesia .....	2
Total .....	32
Skin:	
Pruritic Dermatitis .....	4
Purpura .....	2
Total .....	6
Systemic:	
Extreme Malaise .....	8
Fatigue .....	68
Cyanosis .....	10
Fever .....	3
Anemia .....	4
Total .....	93

It is noteworthy that a number of patients complained of three or four of these various reactions simultaneously. In all of our cases reactions subsided within from one to six days following the withdrawal of the drug and the increase in the fluid intake. No permanent deleterious effects were noted. In all of our cases of maculo-papular dermatitis there was a disagreeable associated pruritus. In one case of the purpura the purpuric areas were exquisitely sensitive and the other insensitive. In one case of febrile reaction seen in consultation, the elevation of temperature reached one hundred four degrees and dropped to normal within eighteen hours after withdrawal of the drug and intravenous infusion. Several instances of fatigue have been profound. In three cases individuals required assistance home from work.

The dosage apparently did not greatly in-

fluence the reaction of the patient, some of our worst reactions having occurred on relatively small dosage of thirty grains daily whereas a number of cases showed no untoward effect from eighty grains daily. With very rare exceptions the patient complaining of reaction suffered identical reaction if the drug was re-instituted and we must agree with Brunsting and others that about ten per cent of cases were intolerant to the drug from some viewpoint. Skin tests were attempted to determine hypersensitivity and met with apparent failure in the experience of several authors<sup>12,14,22</sup> as well as in that of one of us (J. F. Harrold). It would appear impossible to predict any of the toxic manifestations from this drug as they might obtain on the patient for whom we may wish it employed.

In our experience the female apparently tolerates the drug less well. Further, that this individual idiosyncrasy or sensitivity does apparently bear relation to average dosage. Thirty-nine of our cases reacted on moderate dosage, forty grains daily or less, whereas sixty-seven reacted upon dosage from forty to eighty grains daily.

Anemia to a rather alarming degree requiring transfusion, intravenous fluid, and supportive treatment was seen in one case. However, the response of the hematopoietic system even here appeared to us surprisingly gratifying. Long,<sup>19</sup> in a personal communication, stated that he had observed approximately a dozen cases of hemolytic anemia and two cases of agranulocytosis following the use of sulfanilamide. All recovered although in one of the anemias the hemolysis was so acute that the renal tubules became occluded and a subsequent renal insufficiency developed for a time. Further, he felt that the occasional cases in which severe blood changes developed were unpredictable. While in our modest series no permanent untoward results have presented, nevertheless, certain authors, specifically Frost<sup>21</sup> and Borst<sup>1</sup> reported deaths from the use of this drug.

In considering the beneficial results of the drug we have been extremely encouraged and have felt that it has become our strongest form of attack against organisms invading the uro-genital tract. Walther<sup>25</sup> states, "The final verdict is given not in the laboratory but from the knowledge gained in experience at the bedside."

**Pyelitis**

The results obtained in its use in pyelitis are as shown in Table II.

TABLE II

Female .....	44
Male .....	7
Acute .....	23
Chronic .....	28
Complications:	
Hydronephrosis .....	6
Renal Ptosis .....	1
Culturally Negative .....	26
Symptomatic Improvement .....	21
No Benefit .....	4

In this group of cases the offending organisms were almost equally divided between staphylococci and members of the colon group with few streptococci infections. The results obtained were apparently equally beneficial in all types of infection except streptococcus faecalis. Helmholz<sup>15</sup> in his observations apparently felt that the drug is more efficacious than mandelic acid in all forms of urinary tract infection, both upper and lower, save in the case of the streptococcus faecalis. In seventeen of these cases of pyelitis in the female there was a definite associated cicatricial urethritis which was treated concomitantly by urethral dilations.

**Postoperative Infections**

Of twenty postoperative cases (renal, bladder, or prostatic) with residual infection to whom the drug was administered, the infection was eradicated in eight, the patient entirely symptomatically relieved in eight, while in four there was no apparent benefit.

**Non-specific Prostatitis and Urethritis**

Success rewarded our efforts to a far greater extent in these cases of prostatitis which were treated by massage and irrigations in conjunction with sulfanilamide therapy than we had ever before attained. The symptomatic relief was spectacular and the diminution of the white count in the prostatic fluid usually occurred with surprising rapidity. However, Clark<sup>4</sup> found that when the drug had been discontinued infection not infrequently again became manifest in the prostate.

In those cases noted as symptomatically relieved there was definite improvement microscopically though not completely to normal in the character of the fluid when

last seen. In the cases of urethral stricture all had associated urethral discharge. It is scarcely necessary to state that urethral dilations were carried out, sulfanilamide being administered in conjunction. The results were uniformly satisfactory.

TABLE III. NON-SPECIFIC LOWER TRACT INFECTIONS IN THE MALE

Prostatitis:	
Clinically Cured .....	16
Symptomatically Improved .....	6
No Results .....	3
Total .....	25
Urethral Stricture with Urethritis:	
Clinically Cured .....	5
Symptomatically Relieved .....	2
Total .....	7

**Gonorrhea**

Without doubt sulfanilamide has gained its exalted reputation both among the laity and the physicians of the country because of its reported amazing benefit in the treatment of gonorrhea. Prior to its introduction certainly no drug given by mouth deleteriously affected the growth of this organism to any appreciable degree. The exact method of its bactericidal action is as yet apparently not clearly understood, but, to quote Pittman,<sup>23</sup> "It possesses some peculiar characteristic which enables it to succeed where other methods fail." In view of the fact that previous therapy given either intravenously or by mouth rarely influenced the course of gonorrheic infection we must wonder as to how or why this drug should succeed where others have failed. This point may undoubtedly be explained from the fact that R. D. Herrold<sup>16,17</sup> has demonstrated its presence in the prostatic fluid, in the washings of the urethra, as well as in the urine, which observation has been substantiated by Helmholz<sup>15</sup> and Buchtel<sup>7</sup> with relation to prostatic fluid.

To us the publication of the paper by Colston and Dees<sup>8</sup> seemed at least premature and after careful perusal of their article we were unable to discover that they had applied any of the standard criteria of cure in reporting the results of the nineteen cases treated. If provocative efforts were made they were not mentioned so that true eradication of the infection would seem to have remained unproven. In evaluating the series of cases which have come under our observation we should like to mention the



steps taken in our predication of cure. With the cessation of all clinical and symptomatic manifestations the anterior urethra has been sounded and reaction sought. If unable to obtain reaction the sound has subsequently been passed to the posterior urethra. Again failing reaction, the patient has been given alcohol in the form of beer under direct supervision in our office in order that we may be assured that excess is not ingested and uncontrolled reaction occur. Lastly, instillation of one per cent silver nitrate is made. To date if all of these measures and precautions have been taken and have failed to erupt the gonococcus, we have not encountered what we have felt was a subsequent recurrence of infection. We have chosen Wishengrad's<sup>26</sup> interpretation of the time elapsed to accomplish such cure. In other words, the patient may be said to have been cured when the first provocative measure has been negative, providing subsequent provocative measures have not caused exacerbation. With this in mind we present the following series of cases. There were ninety-nine cases of gonorrhea, eighty-five male and fourteen female. The results of treatment were then classified as follows: Cured, fifty-five; symptomatically improved, seventeen; no benefit, seven; lost, six. The duration of infection with and without sulfanilamide may be seen in Table IV.

TABLE IV. FIFTY CASES OF GONORRHEA TREATED PREVIOUS TO SULFANILAMIDE

<i>Duration</i>	<i>Days</i>
Average .....	104
Shortest .....	31
Longest .....	323 plus 5 months
<i>Duration of Infection with Gonorrhea in the Male Treated by Sulfanilamide</i>	
<i>Duration (Acute)</i>	<i>Days</i>
Average .....	21
Shortest .....	6
Longest .....	39
<i>(Chronic)</i>	
Average .....	45
Shortest .....	6
Longest .....	136

It has been impressed upon us in a review of fifty cases of gonorrhea prior to the advent of sulfanilamide that a larger percentage of cases have stayed under medical supervision than previously, undoubtedly due to a very material diminution in the period of treatment necessary. Upon review of our own cases both before and after the introduction of this drug the incidence of lost cases was at least six to one before, and

after its use we find that the percentage of cases cured to our satisfaction and carried through to discharge has increased in approximately the same ratio, which has been in fact both enlightening and encouraging. The average duration of infection in acute gonorrhea was found to be twenty-one days. Turner<sup>24</sup> also felt that the majority of his cases were cured in the third week. That of chronic cases was forty-five days. Complications were minimal in both instances and were markedly reduced in frequency. In early cases the incidence of invasion of the posterior urethra was very definitely diminished.

From these observations, namely, the average duration of infection with gonorrhea prior to the use of sulfanilamide and subsequent to its use, one cannot help but reach the conclusion that the drug has been of inestimable assistance from every viewpoint when tolerated. We were further interested in a comparison of the use of the drug with and without supportive treatment and demonstrated to our own complete satisfaction that concomitant therapy further minimizes the duration of the infection and is of material assistance in the eradication of the disease.

Treatment by urethral instillation in our office has been that of acriflavine and gelatin and occasionally self-instillation by the patient of acriflavine 1:4000 or protargol one-quarter of one per cent. A study of Table V will support our contention.

TABLE V. AVERAGE DURATION OF INFECTION IN CASES TREATED WITH SULFANILAMIDE ALONE AND WITH CONCOMITANT THERAPY

Sulfanilamide Only .....	65 days +
Includes cases lost, duration unknown.	
Sulfanilamide Combined:	
Chronic .....	45 days
Acute .....	21 days

We should like to emphasize that the duration of infection has been determined to the best of our ability by careful provocative procedures and that in many of our patients symptomatic relief has occurred in as short a period as twenty-four hours, very particularly in acute cases when the discharge has entirely disappeared within twenty-four hours never to return. We have not felt, however, that the goal has been attained with the disappearance of the discharge, particularly in view of the fact

that with cessation of the drug all clinical manifestations have only too frequently recurred and in several instances in which the patient felt that cure had been accomplished other members of the family have become infected.

While not exactly pertinent but nevertheless of considerable interest to us, we reviewed such cases as had been under treatment in our hands for previous infection and should like to present illustrative cases.

Lastly, the duration of the disease in the same infection is shown prior to the advent of sulfanilamide and following its administration.

TABLE VI. COMPARATIVE RESULTS IN THE SAME PATIENT IN SEPARATE INFECTIONS

Patient	Without Sulfanilamide	With Sulfanilamide
HB.	31 days	6 days
J.V.	117 days	37 days
B.M.	68 days	14 days
B.K.	210 days	14 days

*Cases of Chronic Gonorrhea Prior to and After Administration of Sulfanilamide*

Without Sulfanilamide	With Sulfanilamide
1. 136 days	Cured in 15 days
2. 115 days	Cured in 13 days
3. 42 days	Cured in 58 days

The average total dosage used in acute gonorrhea was 450 grains. The average total dosage in chronic gonorrhea with supportive treatment was 820 grains. The average used in chronic gonorrhea without other treatment was 1,445 grains. Thus, by the amount of the drug necessary it would further appear that supportive treatment was definitely beneficial.

### Conclusions

1. We have determined to our satisfaction that sulfanilamide is of very material help and assistance in the eradication of the infection of the urinary tract.

2. That more than fifty per cent of patients receiving this drug will experience some degree of reaction which may not be prophesied and that a small group may develop extreme reactions.

3. It has contributed more to the favorable outcome of gonorrhea than any form of treatment previously advocated.

4. Many more patients remain under treatment until cured than formerly.

5. Because of the above fact it is a remarkable advance in the attempt at eradication of gonorrhea.

6. The treatment of gonorrhea is more efficacious with supportive urethral and other standard therapy than without.

Since the presentation of this paper, Oct. 23, 1937, the authors have observed an additional one hundred cases which have served to substantiate conclusions drawn, save that doses of 80 grains daily have been discontinued almost entirely in favor of a maximum dose of 60 grains daily with resulting diminution of reactions.

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# Michigan State Medical Society

## Roster 1938

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Damstra, H. J.....Wayland  
Dickinson, C. A.....Wayland  
Flinn, C. C.....Allegan  
Hamelink, M. H.....Hamilton  
Hudnutt, Orrin D.....Plainwell

Johnson, E. B.....Allegan  
Johnson, H. H.....Martin  
Mahan, James E.....Allegan  
Medill, W. C.....Plainwell  
Osmun, E. D.....Allegan  
Quine, R. C.....Fennville  
Ramseyer, Gladwin E.....Plainwell

Rigterink, George H.....Hamilton  
Shepard, Lyle.....Otsego  
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Ballard, S. L.....Bay City  
Ballard, W. R.....Bay City  
Berman, Harry.....Omer  
Boulton, A. O. (Emeritus)...Gladwin  
Brown, G. M.....Bay City  
Chapman, E. J.....Bay City  
Criswell, R. H.....Bay City  
Dickinson, John W.....Oscoda  
Drummond, Fred.....Kawkawlin  
Dumond, V. H.....Bay City  
Ely, Nina.....Bay City  
Foster, L. Fernald.....Bay City  
Freel, John A.....Bay City  
Gamble, Wm. G., Jr.....Bay City  
Groomes, Charles.....Bay City  
Grosjean, J. C.....Bay City  
Gunn, Robert.....Standish  
Gustin, J. W.....Bay City  
Hagleshaw, G. L.....Bay City  
Hasty, Earl.....Whittemore

Healy, Gaillard H.....Bay City  
Hess, C. L.....Bay City  
Heuser, Harold.....Bay City  
Horowitz, S. Franklin.....Bay City  
Huckins, E. S.....Bay City  
Hughes, E. C.....Bay City  
Husted, F. Pitkin.....Bay City  
Jacoby, A. H.....Bay City  
Jens, Otto.....Essexville  
Jones, Jerry M.....Bay City  
Kerr, Wm.....Bay City  
Kessler, Mana.....Bay City  
Kessler, Saba.....Bay City  
Kowals, F. V.....Bay City  
LaPorte, L. A.....Gladwin  
Leininger, J. W. (Emeritus)..Gladwin  
Levant, Arthur B.....Bay City  
McCarroll, James C.....Bay City  
McDowell, Guy Marshall....Howell  
McEwan, J. H.....Bay City  
Medvesky, M. J.....Bay City  
Miller, Edwin C.....Bay City  
Miller, Maurice C.....Auburn  
Mitton, O. W.....East Tawas

Moore, George W.....Bay City  
Moore, Neal R.....Bay City  
Mosier, D. J.....Bay City  
Perkins, Roy C.....Bay City  
Pearson, Stanley M.....Bay City  
Reutter, C. W.....Bay City  
Scrafford, Royston E.....Bay City  
Sherman, R. N.....Bay City  
Slattery, M. R.....Bay City  
Speckhard, A. O.....Bay City  
Stinson, W. S.....Bay City  
Swantek, Charles M.....Bay City  
Sweet, Irving.....Sterling  
Tarter, Clyde S.....Bay City  
Thiehoff, E. V.....Gladwin  
Tupper, Virgil L.....Bay City  
Urmston, Paul R.....Bay City  
Warren, E. C.....Bay City  
Weed, John.....Tawas City  
Westman, R.....Bay City  
Wilcox, J. W.....Bay City  
Wilson, Thomas G.....Bay City  
Wittwer, E. A.....Bay City  
Ziliak, A. L.....Bay City

### Berrien County

Allen, Robert C.....St. Joseph  
Barkman, F. J.....St. Joseph  
Bartlett, W. M.....Benton Harbor  
Bliesmer, A. F.....St. Joseph  
Brown, F. W.....Watervliet  
Cawthorne, H. J.....Benton Harbor  
Colef, Irving.....Benton Harbor  
Conybeare, R. C.....Benton Harbor  
Dunnington, R. N.....Benton Harbor  
Eidson, Hazel.....Berrien Springs  
Ellet, W. C.....Benton Harbor  
Emery, Clayton.....St. Joseph  
Fredrickson, H. C.....Buchanan  
Friedman, Morris.....New Buffalo  
Gillette, Clarence H.....Niles  
Gunn, J. W.....Watervliet  
Hanna, P. G.....St. Joseph

Harper, Ina.....Benton Harbor  
Harrison, L. L.....Niles  
Helkie, Wm. L.....Three Oaks  
Hershey, Noel J.....Niles  
Higbee, Frank O.....Three Oaks  
Herring, Nathaniel A.....Niles  
Ingleright, Leon R.....Niles  
King, Frank, Jr.....Benton Harbor  
King, Frank A., Sr.....Benton Harbor  
Kling, H. C.....Niles  
Kok, Harry.....Benton Harbor  
Kotler, M. J.....Coloma  
Lapin, Morley.....Benton Harbor  
McDermott, J. J.....St. Joseph  
Merritt, Charles W.....St. Joseph  
Miller, E. A.....Berrien Springs  
Mitchell, Carl A.....Benton Harbor

Moody, Harold.....St. Joseph  
Moore, T. Scott.....Niles  
Reagan, Robert E.....Benton Harbor  
Richmond, D. M.....St. Joseph  
Robson, Verna.....Berrien Springs  
Silverstein, Joseph S.....Benton Harbor  
Smith, W. A.....Berrien Springs  
Sowers, B. F.....Benton Harbor  
Strayer, J. C.....Buchanan  
Taber, R. B.....Benton Harbor  
Vary, Edwin P.....Niles  
Weil, Leonard.....Benton Harbor  
Westervelt, H. O.....Benton Harbor  
Witt, Edw. J. (Retired).....  
Los Angeles, Calif.  
Yeomans, T. G.....St. Joseph

### Branch County

Aldrich, Napier S.....Coldwater  
Beck, Perry C.....Bronson  
Bien, W. J.....Coldwater  
Brunson, A. E.....Colon  
Culver, Bert W.....Coldwater  
Danley, W. E.....Union City  
Far, S. E.....Quincy

Fraser, R. J.....Bronson  
Gist, L. L.....Coldwater  
Holbrook, A. G.....Coldwater  
Leader, F. S.....Coldwater  
McLain, R. W.....Jackson  
Meier, H. J.....Coldwater  
Mooi, H. R.....Coldwater

Olmsted, Kenneth L.....Coldwater  
Phillips, F. L.....Bronson  
Schultz, Samuel.....Coldwater  
Scovill, H. A.....Union City  
Thomas, J. A.....Coldwater  
Wade, R. L.....Coldwater  
Weidner, H. R.....Coldwater

# ROSTER MICHIGAN STATE MEDICAL SOCIETY

## Calhoun County

Allen, Herbert R.....Battle Creek  
Amos, Norman H.....Battle Creek  
Baribeau, R. H.....Battle Creek  
Barnhart, Samuel E.....Battle Creek  
Becker, H. F.....Battle Creek  
Beuker, Herman.....Marshall  
Black, Paul A. L.....Wilmington, N. C.  
Bonifer, Philip.....Battle Creek  
Brainard, C. W.....Battle Creek  
Byland, N. O.....Battle Creek  
Campbell, Alice.....Albion  
Campbell, R. J.....Battle Creek  
Capron, Manley J.....Battle Creek  
Church, Starr K.....Marshall  
Chynoweth, W. R.....Battle Creek  
Cooper, J. E.....Battle Creek  
Curry, Robert K.....Homer  
Derickson, E. C.....Burlington  
Dickson, A. R.....Battle Creek  
Dodge, Warren M., Jr.....Battle Creek  
Dugan, Wm. M.....Battle Creek  
Fahndrich, C. G.....Battle Creek  
Finch, D. L.....Augusta  
Fopeano, John V.....Battle Creek  
Fraser, R. H.....Battle Creek  
Funk, L. D.....Athens  
Gething, Joseph V.....Battle Creek  
Giddings, A. M.....Battle Creek  
Gilfillan, Margery J.....Battle Creek  
Godfrey, W. L. (Honorary).....Battle Creek  
Gordon, J. K. M.....Battle Creek  
Gorsline, Clarence S.....Battle Creek  
Hafford, A. T.....Albion  
Hafford, George C.....Albion  
Hansen, E. L.....Battle Creek  
Harris, Rowland H.....Battle Creek  
Haughey, Wilfrid.....Battle Creek

Haughey, Wm. H. (Honorary)....Battle Creek  
Heald, C. W.....Battle Creek  
Henderson, Louis M.....Albion  
Henderson, Phillip.....Albion  
Herzer, Henry A.....Albion  
Hills, C. R.....Battle Creek  
Holes, Jesse J.....Battle Creek  
Holtom, B. G.....Battle Creek  
Howard, W. L.....Battle Creek  
Hoyt, Aura A.....Battle Creek  
Humphrey, Archie E.....Marshall  
Humphrey, Arthur A.....Battle Creek  
Jespersion, Lydia.....Battle Creek  
Johnson, O. J.....Marshall  
Jones, T. K.....Marshall  
Keagle, Leland R.....Battle Creek  
Keeler, K. B.....Albion  
Kellogg, Carrie S.....Battle Creek  
Kellogg, John H.....Battle Creek  
Kingsley, Paul C.....Battle Creek  
Kinde, M. R.....Battle Creek  
Kinzel, R. W.....Battle Creek  
Kolvoord, Theodore.....Battle Creek  
LaFrance, Francis.....Battle Creek  
Landon, Charles C.....Battle Creek  
Lanman, Everett L.....Battle Creek  
Lewis, W. B.....Battle Creek  
Lowe, H. M.....Battle Creek  
Lowe, Kenneth.....Battle Creek  
Lowe, Stanley T.....Battle Creek  
MacGregor, Archibald.....Battle Creek  
Martin, Walter F.....Battle Creek  
McNair, Lawrence.....Albion  
Melges, F. J.....Battle Creek  
Mercer, C. M.....Battle Creek  
Morrison, Donald B.....Tekonsha  
Mortensen, Martin A.....Santa Clara, Calif.

Moshier, Bertha.....Battle Creek  
Mustard, Russell.....Battle Creek  
Nelson, Albert W.....Battle Creek  
Olsen, A. B.....Battle Creek  
Overholt, B. M.....Battle Creek  
Patterson, A.....Battle Creek  
Pritchard, J. Stuart.....Battle Creek  
Putman, W. N.....Battle Creek  
Radabaugh, Clara V.....Battle Creek  
Riley, Wm. H.....Battle Creek  
Robbert, John.....Climax  
Rorick, Wilma W.....Battle Creek  
Rosenfeld, Jos. E.....Battle Creek  
Roth, Paul.....Battle Creek  
Royer, C. W.....Battle Creek  
Royer, W. A.....Battle Creek  
Selmon, Bertha L.....Battle Creek  
Sharp, A. D.....Albion  
Shipp, L. P.....Battle Creek  
Simpson, R. S.....Battle Creek  
Slagle, Geo. W.....Battle Creek  
Sleight, James D.....Battle Creek  
Sleight, Raymond D.....Battle Creek  
Smith, T. C.....Athens  
Stadle, Wendell H.....Battle Creek  
Stewart, Charles E.....Battle Creek  
Stiefel, Richard A.....Battle Creek  
Tannenholz, Harold S.....Battle Creek  
Taylor, Clifford B.....Albion  
Upson, W. O.....Battle Creek  
Van Camp, Elijah.....Battle Creek  
Vander Voort, W. V.....Battle Creek  
Verity, Lloyd E.....Battle Creek  
Vollmer, Maud J.....Moline, Ill.  
Walters, F. R.....Battle Creek  
Wencke, Carl G.....Battle Creek  
Whyte, Bruce.....Battle Creek  
Winslow, R. C.....Battle Creek

## Cass County

Adams, U. M.....Marcellus  
Bryant, S. E.....Dowagiac  
Clary, R. I.....Dowagiac  
Cunningham, E. M.....Cassopolis  
Harmon, C. M.....Cassopolis

Hickman, John.....Dowagiac  
Jones, John H.....Dowagiac  
Kelsey, James H.....Cassopolis  
Loupee, George.....Dowagiac  
Loupee, S. L.....Dowagiac

Lyman, W. R.....Dowagiac  
Myers, Charles M.....Dowagiac  
Newsome, Otis.....Cassopolis  
Pierce, Kenneth C.....Dowagiac  
Zwergel, E. H.....Cassopolis

## Chippewa-Mackinac Counties

Bandy, F. C.....Sault Ste. Marie  
Birch, Wm.....Sault Ste. Marie  
Blain, James G.....Sault Ste. Marie  
Conrad, George A.....Sault Ste. Marie  
Cornell, Eliphalet A. (Honorary).....Sault Ste. Marie  
Darby, J. F.....St. Ignace  
Edmison, W. C.....St. Ignace

Ennis, C. J. (Honorary).....Sault Ste. Marie  
Gilfillan, E. O.....Sault Ste. Marie  
Husband, F. H.....Sault Ste. Marie  
Littlejohn, David.....Sault Ste. Marie  
McBryde, Lyman M.....Sault Ste. Marie  
Mertough, W. F.....Sault Ste. Marie  
Moloney, F. J.....Sault Ste. Marie

Montgomery, B. T.....St. Ignace  
Reese, J. A.....DeTour  
Scott, Dwight F.....Sault Ste. Marie  
Vegors, S. H.....Sault Ste. Marie  
Wallen, LeRoy J.....Sault Ste. Marie  
Webster, E. H.....Sault Ste. Marie  
Willison, C.....Sault Ste. Marie  
Yale, I. V.....Sault Ste. Marie

## Clinton County

Foo, Charles T.....St. Johns  
Frace, Guy H.....St. Johns  
Hart, Dean W.....St. Johns  
Henthorn, A. C.....St. Johns

Ho, Thomas Y.....St. Johns  
Luton, F. E.....St. Johns  
MacPherson, D. H.....Fowler

McWilliams, W. B.....Maple Rapids  
Richards, F. D.....De Witt  
Russell, Sherwood R.....St. Johns

## Delta County

Bachus, Arthur.....Bark River  
Bartley, George C.....Escanaba  
Benson, G. W.....Escanaba  
Boyce, D. H.....Escanaba  
Carlton, A. J.....Escanaba  
Chenoweth, Nancy R.....Escanaba  
Defnet, Harry J.....Escanaba  
Diamond, F. J.....Gladstone

Diamond, J. A.....Gladstone  
Frenn, Nathan J.....Bark River  
Groos, Harold Q.....Escanaba  
Groos, Louis P.....Escanaba  
Hult, Otto S.....Gladstone  
Kitchen, A. S.....Escanaba  
Lanting, R.....Escanaba  
Lemire, Wm. A.....Escanaba

Long, Harry W.....Escanaba  
Miller, Albert H.....Gladstone  
Mitchell, James D.....Gladstone  
Moll, G. W.....Escanaba  
Treiber, Louis P.....Escanaba  
Walsh, J. J.....Escanaba  
Witters, Josef E.....Nahma

## Dickinson-Iron Counties

Alexander, W. H.....Iron Mountain  
Anderson, E. B.....Iron Mountain  
Baron, B. C.....Crystal Falls  
Boyce, George H.....Iron Mountain  
Brownning, James L.....Iron Mountain  
Camper, T. E.....Stambaugh  
Crowell, Joseph A.....Iron Mountain  
De Salvo, F.....Niagara, Wis.

Fiedling, Wm.....Norway  
Frederickson, G. A.....Iron Mountain  
Haight, H. H.....Crystal Falls  
Hamlin, Lloyd E.....Norway  
Hayes, R. E.....Sagola  
Huron, W. H.....Iron Mountain  
Irvine, L. E.....Iron River  
Kofmehl, Wm. J.....Stambaugh

Larson, H. J.....Crystal Falls  
Levine, D. A.....Iron River  
Libby, Edward M.....Iron River  
Menzies, Clifford.....Iron Mountain  
Merritt, C. E.....Iron Mountain  
Smith, Donald R.....Iron Mountain  
Walker, Claude W.....Iron Mountain  
White, Robert E.....Stambaugh



Eaton County

Anderson, K. A.....Charlotte  
Arner, Fred L.....Bellevue  
Bradley, James B.....Eaton Rapids  
Brown, B. Phillip.....Charlotte  
Burdick, Austin F.....Grand Ledge  
Burlison, A. H. (Honorary)...Olivet  
Engle, Paul.....Olivet  
Gibson, T. E.....Charlotte  
Hargrave, Don V.....Eaton Rapids  
Huber, Charles D.....Charlotte

Imthun, Edgar F.....Grand Ledge  
Lawther, John.....Charlotte  
Lown, C. A.....Grand Ledge  
McLaughlin, C. L. D...Vermontville  
Moyer, H. A.....Charlotte  
Myers, Albert W.....Pottersville  
Paine, E. M., Sr.....Grand Ledge  
Paine, E. Madison, Jr...Grand Ledge  
Quick, Phil H.....Olivet  
Rickerd, Vinton J.....Charlotte

Sackett, C. S.....Charlotte  
Sassaman, F. W.....Charlotte  
Sevener, C. J.....Charlotte  
Sevener, Lester G.....Charlotte  
Sheets, A. G.....Eaton Rapids  
Stanka, Andrew G.....Grand Ledge  
Stimson, C. A.....Eaton Rapids  
Van Ark, Bert.....Eaton Rapids  
Wilensky, Thomas.....Eaton Rapids

Genesee County

Backus, G. R.....Flint  
Bahlman, Gordon H.....Flint  
Baird, James.....Flint  
Bald, Fred W.....Flint  
Baske, Franklin W.....Flint  
Bateman, L. G.....Flint  
Benson, J. C.....Flint  
Biggar, H. R.....Flint  
Bishop, D. L.....Flint  
Blakeley, A. C.....Flint  
Bogart, Leon M.....Flint  
Boles, Wm. P.....Flint  
Bonathan, A. T.....Flint  
Bradley, Robert.....Flint  
Brain, R. Gordon.....Flint  
Brasie, D. R.....Flint  
Briggs, Guy D.....Flint  
Burnell, B. E.....Flint  
Burnell, Max.....Flint  
Chambers, Myrton S.....Flint  
Charters, John H.....Flushing  
Childs, Lloyd H.....Flint  
Clark, Clifford P.....Flint  
Colwell, C. W.....Flint  
Connell, J. T.....Flint  
Conover, G. V.....Flint  
Conover, T. S.....Flint  
Cook, Henry.....Flint  
Covert, F. L.....Gaines  
Credille, B. A.....Flint  
Curry, George.....Flint  
Curtin, J. H.....Flint  
Dimond, E. G.....Flint  
Dodds, F. E.....Flint  
Drewyer, Glen.....Flint  
Edgerton, A. C.....Clio  
Finkelstein, T.....Flint  
Flynn, S. T.....Flint  
Foley, S. I.....Flint  
Fuller, H. T.....Mt. Morris  
Gelenger, S. M.....Flint

Gleason, N. Arthur.....Flint  
Goering, Geo. R.....Flint  
Golden, H. Maxwell.....Flint  
Goodfellow, B. J.....Flint  
Gorne, S. S.....Flint  
Graham, H.....Mt. Morris  
Guile, Earle.....Flint  
Guile, G. S.....Flint  
Gundry, G. L.....Grand Blanc  
Hague, R. F.....Flint  
Halligan, Raymond S.....Flint  
Handy, John W.....Flint  
Harper, A. W.....Flint  
Harper, Homer.....Flint  
Hawkins, James E.....Flint  
Hiscock, H. H.....Flint  
Houston, James.....Swartz Creek  
Hubbard, Wm. B.....Flint  
Johnson, F.....Flint  
Kirk, A. Dale.....Flint  
Kretchmar, A. H.....Flint  
Lavin, Kathryn R.....Flint  
Logan, G. W.....Flushing  
MacDuff, R. B.....Flint  
MacGregor, D. M.....Flint  
MacGregor, R. W.....Flint  
Macksood, Joseph.....Flint  
Malfroid, B. W.....Flint  
Marsh, H.....Flint  
Marshall, Wm. H.....Flint  
Mason, Elta.....Flint  
Matthewson, Guy C.....Flint  
McArthur, A.....Flint  
McGarry, Burton G.....Fenton  
McGarry, R. A.....Flint  
McGregor, James C.....Flint  
McKenna, O. W.....Flint  
Miner, F. B.....Flint  
Morrish, Ray S.....Flint  
Morrisey, V. H.....Flint  
Mosier, Edward C.....Otisville

Odle, Ira.....Flint  
Orr, J. Walter.....Flint  
Paul A. T.....Flint  
Pfeiffer, A. C.....Mt. Morris  
Phillips, R. L.....Flint  
Pratz, O. C.....Flint  
Preston, Otto.....Flint  
Randall, H. E.....Flint  
Reeder, Frank E.....Flint  
Reid, Wells C.....Goodrich  
Richeson, V.....Flint  
Roberts, Floyd A.....Flint  
Rowley, James A.....Flint  
Rundles, Walter Z.....Flint  
Scavarda, Charles J.....Flint  
Scott, R. D.....Flint  
Shantz, L. O.....Flint  
Sleeman, Blythe.....Linden  
Smith, E. C.....Flint  
Sniderman, Benjamin.....Flint  
Sorkin, S. S.....Flint  
Steinman, F. H.....Flint  
Stephenson, Robert A.....Flint  
Stevenson, W. W.....Flint  
Stroup, C. K.....Flint  
Sutherland, James K.....Flint  
Sutton, M. R.....Flint  
Thompson, Alvin.....Flint  
Walden, C. E.....Flint  
Wall, W. J.....Davison  
Wallace, Wm. S.....Flint  
Wark, D. R.....Flint  
Wheelock, A. S.....Flint  
White, C. H.....Fenton  
White, Herbert.....Flint  
Williams, W. S.....Flint  
Willoughby, G. L.....Flint  
Willoughby, L. L.....Flint  
Wills, T. N.....Flint  
Wright, D. R.....Flint  
Wright, G. R.....Montrose  
Wyman, J. S.....Davison

Gogebic County

Anderson, Charles E.....Bessemer  
Byrd, Wallace.....Watersmeet  
Conley, W. C.....Ironwood  
Crosby, Theodore S.....Ironwood  
Eisele, D. C.....Ironwood  
Gertz, M. A.....Ironwood  
Gorrilla, A. C.....Ironwood  
Lieberthal, M. J.....Ironwood  
Lieberthal, Paul.....Ironwood

Maloney, F. G. H.....Ironwood  
Nezowski, H. T.....Ramsay  
O'Brien, A. J.....Ironwood  
Pierpont, D. C.....Ironwood  
Pinkerton, H. A.....Ironwood  
Pinkerton, W. J.....Bessemer  
Prout, Robert L. C.....Wakefield  
Rees, Thomas R.....Ironwood  
Reid, John D.....Ironwood

Reynolds, F. L. S.....Ironwood  
Sarvela, H. L.....Ironwood  
Stevens, Charles E.....Bessemer  
Tew, Wm. Ellwood.....Bessemer  
Tressel, H. A.....Wakefield  
Urquhart, C. C.....Ironwood  
Wacek, W. H.....Ironwood  
Winter, Joseph A.....Ironwood

Grand Traverse-Leelanau-Benzie Counties

Brownson, J. J.....Kingsley  
Bushong, B. B.....Traverse City  
Covey, E. L.....Honor  
Ellis, Claude I.....Suttons Bay  
Flood, Robert E.....Northport  
Gauntlett, J. W.....Traverse City  
Holliday, George A.....Traverse City  
Huston, Russell R.....Elk Rapids  
Jones, Stewart R.....Suttons Bay  
Kitson, V. H.....Elk Rapids  
Kyselka, H. B.....Traverse City

Lemen, Charles E.....Traverse City  
Lossman, R. T.....Traverse City  
Murphy, Fred E.....Cedar  
Nickels, M. M.....Traverse City  
Osterlin, Mark.....Traverse City  
Porter, Clark.....Traverse City  
Quinn, Henry M.....Copemish  
Rennell, E. J.....Traverse City  
Sheets, R. Philip.....Traverse City  
Sladek, E. F.....Traverse City

Smiseth, Selmer P.....Suttons Bay  
Stone, Fordyce H.....Beulah  
Swartz, F. G.....Traverse City  
Thacker, Fred R.....Frankfort  
Thirlby, E. L.....Traverse City  
Thompson, T. W.....Traverse City  
Trautman, Frederick D.....Frankfort  
Way, Lewis R.....Traverse City  
Zielke, I. H.....Traverse City  
Zimmerman, J. G.....Traverse City

Gratiot-Isabella-Clare Counties

Aldrich, Alfred L.....Ithaca  
Barstow, D. K.....St. Louis  
Barstow, W. E.....St. Louis  
Baskerville, C. M.....Mt. Pleasant  
Becker, M. G.....Edmore  
Budge, M. J.....Ithaca  
Burch, L. J.....Mt. Pleasant  
Burt, C. E.....Ithaca  
Carney, T. J.....Alma  
Davis, L. L.....Mt. Pleasant  
Dawson, R. E.....Blanchard  
Drake, Wilkie M.....Breckenridge  
DuBois, C. F.....Alma

Duffy, Ray M.....Breckenridge  
Faber, Michael.....Ashley  
Graham, B. J.....Alma  
Graham, F. J.....Alma  
Hall, B. C.....Pompeii  
Hammerberg, Kuno.....Clare  
Harrigan, W. L.....Mt. Pleasant  
Hersee, Wm. E.....Mt. Pleasant  
Hobbs, A. D.....St. Louis  
Howell, Don M.....Alma  
Hubbard, M. C.....Vestaburg  
Johnson, P. R.....Mt. Pleasant  
Kilborn, H. F.....Ithaca

Lamb, E. T.....Alma  
McArthur, Stewart C.....Mt. Pleasant  
Reeder, J. A.....Clare  
Rondot, E. F.....Lake  
Sanford, B. J.....Clare  
Sarven, J. D.....Middleton  
Slattery, F. G.....Clare  
Strange, Russell H.....Mt. Pleasant  
Waggoner, R. L.....St. Louis  
Wilcox, R. A.....Alma  
Wilson, Earl C.....Harrison  
Wolfe, Kenneth P.....Alma  
Wood, Cornelius B.....Clare



# ROSTER MICHIGAN STATE MEDICAL SOCIETY

## Hillsdale County

Alleger, W. E.....Pittsford  
Bates, James A.....Camden  
Bower, Charles T.....Hillsdale  
Bowers, M. H.....Hillsdale  
Clobridge, G. E.....Allen  
Day, Luther W.....Jonesville  
Ditmars, William H.....Jonesville  
Fisk, F. B.....Jonesville

Green, B. F.....Hillsdale  
Hamilton, A. J.....Hillsdale  
Hanke, George R.....Ransom  
Heald, J. E.....Hillsdale  
Hodge, C. L.....Reading  
Hughes, Henry F.....Hillsdale  
Johnson, James H.....Hillsdale  
Kline, Fred.....Litchfield  
Mattson, H. F.....Hillsdale

Martindale, E. A.....Hillsdale  
McFarland, O. G.....North Adams  
McGavran, E. G.....Hillsdale  
Miller, Harry C.....Hillsdale  
Poppen, C. J.....Reading  
Sterling, John S.....Jerome  
Strom, A. W.....Hillsdale  
Yeagley, J. L.....Waldron

## Houghton-Baraga-Keweenaw Counties

Abrams, James C.....Calumet  
Aldrich, A. B.....Houghton  
Aldrich, Addison D.....Houghton  
Bourland, Philip D.....Calumet  
Brewington, Geo. F.....Mohawk  
Buckland, R. S.....Baraga  
Burke, John.....Hubbell  
Coffin, Leslie E.....Painesdale  
Cooper, C. A.....Hancock  
Gregg, W. T. S.....Calumet  
Hilmer, R. E.....Beacon Hill  
Janis, A. J.....Hancock  
Kadin, Maurice.....Calumet

King, William T.....Ahmeek  
Kirtan, Joseph R. W.....Calumet  
LaBine, Alfred.....Houghton  
Levin, Simon.....Houghton  
Leo, L. S.....Houghton  
Maas, R. J. (Emeritus) ..Houghton  
MacQueen, Donald K.....Laurium  
Manthei, W. A.....Lake Linden  
Marshall, Frank F.....L'Anse  
Quick, James B.....Laurium  
Roberts, Melvin D.....Hancock  
Roche, A. C.....Calumet  
Rupprecht, C. H.....Calumet

Scott, Wm. P. (Emeritus)..Houghton  
Sloan, P. S.....Trimountain  
Stern, Isadore D.....Houghton  
Stewart, G. C.....Hancock  
Stewart, J. C. B.....Painesdale  
Stewart, Marshall.....Houghton  
Tinetti, Ernest F.....Laurium  
Van Slyke, Wm. H.....Hancock  
Waldie, Geo. Mc. L.....Hancock  
Ware, H. M.....Ahmeek  
Wickliffe, T. P.....Calumet  
Winkler, Henry J.....L'Anse

## Huron-Sanilac Counties

Blanchard, E. W.....Deckerville  
Caccamise, Jos. G.....Sebewaing  
Cochran, Lewis E.....Peck  
Gettel, Roy R.....Kinde  
Gaston, Lloyd.....Sandusky  
Gift, W. A.....Marlette  
Hart, R. K.....Croswell  
Henderson, J. Bates.....Pigeon

Herrington, Charles I.....Bad Axe  
Herrington, Willet J.....Bad Axe  
Holdship, William B.....Ubyly  
Kirker, F. O.....Sandusky  
Koch, D.....Brown City  
Learmont, H. H.....Croswell  
Lunn, J. O.....Harbor Beach  
Monroe, Duncan J.....Elkton  
Morden, Charles B.....Bad Axe

Norgaard, Hal V.....Marlette  
Oakes, C. W.....Harbor Beach  
Robertson, Collin G.....Sandusky  
Scheurer, C.....Pigeon  
Thumme, Harrison F.....Sebewaing  
Tweedie, G. Evans.....Sandusky  
Tweedie, S. Martin.....Sandusky  
Webster, John C.....Marlette

## Ingham County

Albers, J. S.....East Lansing  
Barnum, S. V.....Lansing  
Barrett, C. D.....Mason  
Bartholomew, Henry S.....Lansing  
Bauer, Theodore I.....Lansing  
Behen, William C.....Lansing  
Bellinger, E. G.....Lansing  
Bolin, R. S.....Mason  
Bradford, C. W.....Lansing  
Breakey, Robert S.....Lansing  
Brubaker, Earl.....Lansing  
Brucker, Karl B.....Lansing  
Bruegel, Oscar H.....East Lansing  
Burhans, Robert.....Lansing  
Cameron, W. J.....Lansing  
Campbell, A. M.....Lansing  
Carr, Earl I.....Lansing  
Christian, L. G.....Lansing  
Cook, R. J.....Lansing  
Corsaut, J. C.....Mason  
Culver, C. F.....Howell  
Cushman, F. J.....Lansing  
Darling, L. H.....Lansing  
Davenport, C. S.....Lansing  
DeVries, C. F.....Lansing  
Doyle, Charles R.....Lansing  
Doyle, C. P.....Lansing  
Drolett, Fred J.....Lansing  
Drolett, Lawrence.....Lansing  
Dunn, F. C.....Lansing  
Dunn, F. M.....Lansing  
Ellis, Bertha.....Lansing  
Ellis, C. W.....Lansing  
Finch, Russell L.....Lansing  
Fisher, D. W.....Lansing  
Fosget, Wilbur W.....Lansing  
Foust, E. H.....Lansing  
Freeland, O. H.....Mason  
French, Horace L.....Lansing  
Galbraith, Dugald A.....Lansing  
Gardner, C. B.....Lansing  
Gardner, R. E.....Lansing  
Gudakunst, Don W.....Lansing  
Gunderson, G. O.....Lansing  
Guy, Spender D.....Lansing

Hall, R. E.....Dansville  
Hart, L. C.....Lansing  
Haynes, H. B.....Lansing  
Haze, Harry A.....Lansing  
Heckert, Frank.....Lansing  
Heckert, J. K.....Lansing  
Hendren, Owen.....Williamston  
Henry, L.....Lansing  
Hermes, Ed. J.....Lansing  
Himmelberger, R. J.....Lansing  
Hodges, Kenneth P.....Lansing  
Huggett, Clare C.....Lansing  
Huntley, Fred M.....Lansing  
Hurth, M. S.....Lansing  
Johnson, K. H.....Lansing  
Jones, Francis A.....Lansing  
Kalmbach, R. E.....Lansing  
Keim, C. D.....Lansing  
Kent, Edith Hall.....Lansing  
Kent, Herbert K.....Lansing  
Krafts, L. C.....Leslie  
Larabee, E. E.....Williamston  
Loree, Maurice C.....Lansing  
Lucas, T. A.....Lansing  
Ludlum, L. C.....Lansing  
McConnell, E. G.....Lansing  
McCorvie, C. Ray.....East Lansing  
McCoy, Earl M.....Grand Ledge  
McCrumb, R. R.....Lansing  
McGillicuddy, Oliver B.....Lansing  
McGillicuddy, R. J.....Lansing  
McIntyre, J. E.....Lansing  
McNamara, Wm. E.....Lansing  
McPherson, E. G.....Stockbridge  
Mercer, Walter E.....Webberville  
Meyer, H. R.....Lansing  
Miller, H. A.....Lansing  
Miller, Robert E. (Honorary)..Lansing  
Mitchell, A. B.....Lansing  
Morrow, R.....Lansing  
Niles, B. D.....Lansing  
Ochsner, P. J.....Lansing  
Olin, Richard M.....East Lansing  
Osborn, Samuel.....Lansing

O'Sullivan, Gertrude.....Mason  
Owen, A. E.....Lansing  
Peacock, T. L.....Lansing  
Phillips, R. H.....Lansing  
Pinkham, R. A.....Lansing  
Ponton, J.....Mason  
Prall, H. J.....Lansing  
Randall, O. M.....Lansing  
Roberts, D. W.....Lansing  
Robson, Edmund J.....Lansing  
Rockwell, H. C.....Lansing  
Rozan, J. S.....Lansing  
Rozan, M. M.....Lansing  
Russell, Claude V.....Lansing  
Sander, John F.....Lansing  
Sanford, Thomas M.....Lansing  
Seger, Fred L.....Lansing  
Shaw, Milton.....Lansing  
Slemmons, C. C.....Grand Rapids  
Smith, H. M.....Lansing  
Smith, Lillian R.....Lansing  
Snell, Dana M.....Lansing  
Snyder, LeMoyné.....Lansing  
Spencer, Perry.....Lansing  
Steiner, A. A.....Lansing  
Stiles, Frank.....Lansing  
Strauss, P. C.....Lansing  
Stucky, George C.....Lansing  
Toothaker, Kenneth.....Lansing  
Towne, Lawrence C.....Lansing  
Troost, F. L.....Holt  
Vander Slice, E. R.....Lansing  
Vander Zalm, T. P.....Lansing  
Wadley, Ralph.....Lansing  
Warford, J. T.....Lansing  
Webb, Roy O.....Okemos  
Weinburgh, H. B.....Lansing  
Welch, William.....Lansing  
Wetzel, John O.....Lansing  
Wight, W. G.....Lansing  
Wiley, Harold W.....Lansing  
Wellman, John M.....Lansing  
Willson, Howard S.....Lansing  
Wilson, Harry A.....Lansing

## Ionia-Montcalm Counties

Bird, William L.....Greenville  
Bower, A. J.....Greenville  
Braley, Frank.....Saranac  
Bracey, L. E.....Sheridan  
Dunkin, Lloyd S.....Greenville  
Duval, L. E.....Ionia  
Ferguson, F. H.....Carson City  
Fleming, J. C.....Pewamo  
Fox, Harold M.....Portland  
Fuller, Rudolphus W.....Crystal  
Geib, O. P.....Carson City  
Hansen, M. M.....Greenville

Hargrave, F. A. (Emeritus).....Palo  
Haskell, Robert H.....Northville  
Hay, John R.....Saranac  
Hoffs, M. A.....Lake Odessa  
Hollard, A. E.....Belding  
Imus, H. L.....Ionia  
Johns, Joseph J.....Ionia  
Kelsey, L. E.....Lakeview  
Kling, V. F.....Ionia  
Laughlin, A. I.....Clarksville  
La Victoire, I. N.....Ionia  
Lilly, I. S.....Stanton  
Lintner, Roy C.....Ionia

Marsh, F. M.....Ionia  
Marston, L. L.....Lakeview  
Maynard, Herbert M.....Ionia  
McCann, John J.....Ionia  
Norris, William W.....Portland  
Peabody, C. H.....Lake Odessa  
Pankhurst, C. T.....Ionia  
Pinkham, J. F.....Belding  
Robertson, P. C.....Ionia  
Swift, E. R.....Lakeview  
Van Loo, J. A.....Belding  
Whitten, R. R.....Ionia



### Jackson County

Alronheim, J. H.....Jackson  
 Alter, R. H.....Jackson  
 Anderson, W. B.....Jackson  
 Baker, G. M.....Parma  
 Balconi, Henry.....Brooklyn  
 Bartholic, F. W.....Grass Lake  
 Brown, H. A.....Jackson  
 Bullen, G. R.....Jackson  
 Chabut, H.....Jackson  
 Clarke, C. S.....Jackson  
 Cochran, Wayne A.....Jackson  
 Cooley, Randall M.....Jackson  
 Corley, C.....Jackson  
 Corley, Ennis.....Jackson  
 Cox, Ferdinand.....Jackson  
 Crowley, Edw. D.....Jackson  
 Culver, Guy D.....Stockbridge  
 DeMay, C. E.....Jackson  
 Dengler, C. R.....Jackson  
 Edmonds, J. M.....Horton  
 Enders, W. H.....Jackson  
 Finton, Walter L.....Jackson  
 Finton, W. R.....Jackson  
 Foust, W. L.....Grass Lake  
 Gibson, F. J.....Jackson  
 Glover, H. G.....Jackson  
 Greenbaum, Harry.....Jackson  
 Hackett, T. E.....Jackson  
 Hanft, Cyril F.....Springport  
 Hanna, R. J.....Jackson  
 Hardie, G. C.....Jackson  
 Harris, Lester J.....Jackson

Hicks, Glenn C.....Jackson  
 Hoernschemeyer, J. L.....Jackson  
 Hungerford, P. R.....Concord  
 Huntley, W. B.....Jackson  
 Hurley, H. L.....Jackson  
 Keefer, A. H.....Concord  
 Kudner, Don F.....Jackson  
 Kugler, J. C. (Emeritus).....Jackson  
 Lake, Wm. H.....Jackson  
 Lathrop, Wm. W.....Jackson  
 Leahy, E. O.....Jackson  
 Leonard, Clyde A.....Jackson  
 Lewis, E. F.....Jackson  
 Ludwick, J. E.....Jackson  
 McGarvey, W. E.....Jackson  
 McLaughlin, M. J.....Jackson  
 Meads, J. B.....Jackson  
 Munro, C. D.....Jackson  
 Munro, James E.....Jackson  
 Murphy, B. M.....Jackson  
 Newton, R. E.....Jackson  
 O'Meara, James J.....Jackson  
 Otis, G. R.....Jackson  
 Page, John W.....Jackson  
 Peterson, E. S.....Jackson  
 Philips, David P.....Jackson  
 Porter, H. W.....Jackson  
 Pray, Frank F.....Jackson  
 Pray, George R.....Jackson  
 Quillen, R. D.....Chelsea  
 Ransom, F. G.....Jackson  
 Riley, Philip A.....Jackson

Roberts, Arthur J. (Emeritus).....Jackson  
 Schepeler, Cortland W.....Brooklyn  
 Scheurer, P. A.....Manchester  
 Schmidt, T. E.....Jackson  
 Scott, John A.....Jackson  
 Seybold, G. A.....Jackson  
 Shaeffer, A. M.....Jackson  
 Smith, Dean W.....Jackson  
 Smith, John C.....Jackson  
 Snow, W. R.....Jackson  
 Speck, John W.....Jackson  
 Spicer, W. E.....Jackson  
 Stewart, L. L.....Jackson  
 Stewart, Maitland N.....Jackson  
 Stocking, Bruce W.....Jackson  
 Susskind, M. V.....Jackson  
 Tate, Cecil E.....Jackson  
 Thalner, L. F.....Jackson  
 Thayer, E. A.....Jackson  
 Townsend, J. W.....Vandercook Lake  
 Tuthill, F. S.....Concord  
 Van Schoick, J. D.....Hanover  
 Van Schoick, Frank.....Jackson  
 Wertenberger, M. D.....Jackson  
 Wholihan, John W.....Michigan Center  
 Wickham, W. A.....Jackson  
 Wilson, E. D.....Jackson  
 Wilson, E. G.....Jackson  
 Wilson, N. D.....Jackson  
 Winter, G. E.....Jackson  
 Woyt, S. W.....Jackson

### Kalamazoo-Van Buren Counties

Aach, Hugo.....Kalamazoo  
 Adams, R. U.....Kalamazoo  
 Alexander, C. A.....Kalamazoo  
 Ames, Edward (Emeritus).....Kalamazoo  
 Andrews, F. T.....Kalamazoo  
 Andrews, Sherman.....Kalamazoo  
 Armstrong, R. J.....Kalamazoo  
 Balch, R. E.....Kalamazoo  
 Banner, Lawrence R.....Kalamazoo  
 Barnebee, J. Hosea.....Kalamazoo  
 Barnebee, J. W.....Kalamazoo  
 Barrett, F. Elizabeth.....Kalamazoo  
 Bennett, Charles L.....Kalamazoo  
 Bennett, Keith.....Kalamazoo  
 Berry, J. F.....Kalamazoo  
 Bodmer, H. C.....Kalamazoo  
 Bope, Wm. P.....Decatur  
 Borgman, Wallace.....Kalamazoo  
 Boothby, F. M.....Lawrence  
 Boys, C. E.....Kalamazoo  
 Boys, Floyd.....Kalamazoo  
 Braden, G. M. (Emeritus).....Scotts  
 Brown, I. W.....Kalamazoo  
 Burns, J. T.....Kalamazoo  
 Caldwell, George H.....Kalamazoo  
 Cobb, Horace R.....Kalamazoo  
 Collins, Ward E.....Kalamazoo  
 Cook, R. G.....Kalamazoo  
 Crawford, Kenneth.....Kalamazoo  
 Crum, Leo J.....Kalamazoo  
 Dean, Ray.....Three Rivers  
 Den Bleyker, Walter.....Kalamazoo  
 DeWitt, L. H.....Kalamazoo  
 Diephus, Bert.....South Haven  
 Dowd, B. J.....Kalamazoo  
 Doyle, F. M.....Kalamazoo  
 Ertell, Wm. Francis.....Kalamazoo  
 Fast, R. B.....Kalamazoo  
 Fulkerson, C. B.....Kalamazoo  
 Fuller, P. M.....Kalamazoo  
 Fuller, R. T.....Kalamazoo  
 Garrett, Evan.....Hartford  
 Gerstner, Louis W.....Kalamazoo  
 Giffen, John R.....Bangor  
 Gilding, Joseph.....Vicksburg

Gilding, Z. L.....Vicksburg  
 Grant, Frederick E.....Kalamazoo  
 Greenman, Newton H.....Decatur  
 Gregg, Sherman.....Kalamazoo  
 Harter, Randolph S.....Schoolcraft  
 Heersma, H. S.....Kalamazoo  
 Hildreth, R. C.....Kalamazoo  
 Hobbs, E. J.....Galesburg  
 Hodgman, Albert.....Kalamazoo  
 Hoebeke, Wm. G.....Kalamazoo  
 Howard, W. H.....Galesburg  
 Hubbell, R. J.....Kalamazoo  
 Huyser, Wm. C.....Kalamazoo  
 Ilgenfritz, F. M.....Kalamazoo  
 Irwin, Wm. D.....Kalamazoo  
 Itzen, J. F.....South Haven  
 Jackson, John B.....Kalamazoo  
 Jennings, W. O.....Kalamazoo  
 Kenzie, W. N.....Camp Custer  
 Kingma, J. G.....Decatur  
 Klerk, W. J.....Kalamazoo  
 Koestner, P. A.....Kalamazoo  
 Lambert, R. H.....Kalamazoo  
 Lang, W. W.....Kalamazoo  
 Lavender, Howard.....Kalamazoo  
 Light, Richard U.....Kalamazoo  
 Light, S. Rudolph.....Kalamazoo  
 Littig, John.....Kalamazoo  
 Lowe, Edwin G.....Bangor  
 MacGregor, J. R.....Kalamazoo  
 Malone, James G.....Kalamazoo  
 Maxwell, J. C.....Paw Paw  
 McCarthy, J. S.....Kalamazoo  
 McIntyre, C. H.....Kalamazoo  
 McNabb, A. A.....Lawrence  
 McNair, Rush.....Kalamazoo  
 Morter, Roy A.....Kalamazoo  
 Murphy, Norman D.....Bangor  
 Nibbelink, Benjamin.....Kalamazoo  
 Osborne, Charles E.....Vicksburg  
 Patmos, Martin.....Kalamazoo  
 Peelen, J. W.....Kalamazoo  
 Peelen, Matthew.....Kalamazoo  
 Penoyar, C. L.....South Haven  
 Perry, Clifton.....Kalamazoo

Pratt, F. A.....Kalamazoo  
 Prentice, Hazel R.....Kalamazoo  
 Pullon, A. R.....Kalamazoo  
 Rickert, John A.....Allegan  
 Rigterink, H. A.....Kalamazoo  
 Riley, G. M.....Gobles  
 Rockwell, A. H. (Emeritus).....Kalamazoo  
 Rockwell, Donald C.....Kalamazoo  
 Sage, E. D.....Kalamazoo  
 Scholten, D. J.....Kalamazoo  
 Scholten, Wm.....Kalamazoo  
 Schrier, C. M.....Kalamazoo  
 Schrier, Paul.....Kalamazoo  
 Schrier, Thomas.....Comstock  
 Scott, Wm. A.....Kalamazoo  
 Sears, H. A.....Kalamazoo  
 Shackleton, Wm. E.....Kalamazoo  
 Shepard, Benjamin A.....Kalamazoo  
 Shook, R. W.....Kalamazoo  
 Snyder, Roscoe F.....Kalamazoo  
 Southworth, M. N.....Schoolcraft  
 Spalding, R. W.....Gobles  
 Squires, David E.....Kalamazoo  
 Stewart, L. H.....Kalamazoo  
 Ten Houten, Chas.....Paw Paw  
 Terwilliger, Edwin.....South Haven  
 Unrath, Clara.....Kalamazoo  
 Upjohn, E. Gifford.....Kalamazoo  
 Upjohn, L. N.....Kalamazoo  
 Van Ness, J. Howard.....Allegan  
 Van Urk, Thomas.....Kalamazoo  
 Volderauer, John.....Kalamazoo  
 Wagar, Carl.....Schoolcraft  
 Walker, Burt D.....Kalamazoo  
 Weirich, Richard.....Marcellus  
 West, A. E.....Kalamazoo  
 Westcott, L. E.....Kalamazoo  
 Wilbur, E. P.....Kalamazoo  
 Wilkinson, Chester A.....Kendall  
 Williams, F. N.....Hartford  
 Youngs, A. S.....Kalamazoo  
 Youngs, C. A.....Kalamazoo  
 Young, Wm. R.....Lawton

### Kent County

Adams, F. A.....Grand Rapids  
 Aitken, George T.....Grand Rapids  
 Bachman, G. A.....Grand Rapids  
 Baert, George H.....Grand Rapids  
 Baker, Abel J.....Grand Rapids  
 Ballard, M. S.....Grand Rapids  
 Beel, Horace J.....Grand Rapids  
 Beets, W. Clarence.....Grand Rapids  
 Beeman, C. B.....Grand Rapids  
 Beeman, C. E.....Grand Rapids  
 Bettison, Wm. L.....Grand Rapids  
 Billings, Elton P.....Grand Rapids  
 Blackburn, Henry M.....Grand Rapids  
 Bloxson, P. W.....Grand Rapids  
 Boet, F. A.....Grand Rapids  
 Bond, Geo. L.....Grand Rapids

Bosch, L. C.....Grand Rapids  
 Brayman, C. W.....Cedar Springs  
 Brook, Jacob D.....Grandville  
 Brotherhood, J. S.....Grand Rapids  
 Browning, Eugene S.....Grand Rapids  
 Buesing, O. R.....Grand Rapids  
 Bull, Frank L.....Sparta  
 Burling, Wesley M.....Grand Rapids  
 Butler, Wm. J.....Grand Rapids  
 Byers, Earl J.....Grand Rapids  
 Cameron, Don B.....Grand Rapids  
 Campbell, Alexander M.....Grand Rapids  
 Cardwell, John F.....Grand Rapids  
 Chadwick, Ward L.....Grand Rapids  
 Chamberlain, L. H.....Grand Rapids  
 Chandler, Donald.....Grand Rapids

Cilley, E. O.....Grand Rapids  
 Claytor, R. W.....Grand Rapids  
 Collisi, H. S.....Grand Rapids  
 Colvin, W. G.....Grand Rapids  
 Corbus, Burton R.....Grand Rapids  
 Crane, Charles V.....Grand Rapids  
 Crane, Harold D.....Grand Rapids  
 Currier, Fred P.....Grand Rapids  
 Dales, Ernest W.....Grand Rapids  
 Davis, D. B.....Grand Rapids  
 Dean, Alfred W.....Grand Rapids  
 DeBoer, Guy W.....Grand Rapids  
 Dell, E. E.....Sand Lake  
 DeMaagd, Gerald.....Rockford  
 DeMol, Richard J.....Grand Rapids  
 Denham, R. H.....Grand Rapids



# ROSTER MICHIGAN STATE MEDICAL SOCIETY

DePree, Isla G.....Grand Rapids  
 DePree, Joseph.....Grand Rapids  
 DeVel, Leon.....Grand Rapids  
 DeVries, Daniel.....Grand Rapids  
 Dewar, M. M.....Grand Rapids  
 Dixon, Willis L.....Grand Rapids  
 Droste, James C.....Grand Rapids  
 Eaton, Robert M.....Grand Rapids  
 Eggleston, H. R.....Grand Rapids  
 Ferguson, Lynn A.....Grand Rapids  
 Ferguson, Ward S.....Grand Rapids  
 Ferrand, L. G.....Rockford  
 Fitts, Ralph L.....Grand Rapids  
 Flynn, J. Donald.....Grand Rapids  
 Foshee, J. C.....Grand Rapids  
 Frantz, C. H.....Grand Rapids  
 Fuller, E. H.....Grand Rapids  
 Gainey, James J.....Grand Rapids  
 Gaikema, E. W.....Grand Rapids  
 Greenen, C. J.....Grand Rapids  
 German, William McK.....Grand Rapids  
 Gillett, O. H.....Grand Rapids  
 Grant, Lee O.....Grand Rapids  
 Graybiel, George.....Caledonia  
 Griffith, L. S.....Grand Rapids  
 Hagerman, D. B.....Grand Rapids  
 Hammond, T. W.....Grand Rapids  
 Hartman, Deane C.....Grand Rapids  
 Hayes, L. W.....Howard City  
 Heetderks, Dewey R.....Grand Rapids  
 Henry, James, Jr.....Grand Rapids  
 Herrick, Ruth.....Grand Rapids  
 Hill, A. M.....Grand Rapids  
 Hodgen, J. T.....Grand Rapids  
 Holcomb, John N.....Grand Rapids  
 Holcomb, J. W.....Grand Rapids  
 Holdsworth, M. J.....Grand Rapids  
 Hufford, A. R.....Grand Rapids  
 Hunderman, Edw.....Grand Rapids  
 Hutchinson, Robert J.....Grand Rapids  
 Hyland, Wm. A.....Grand Rapids  
 Irwin, Thomas C.....Grand Rapids  
 Ingersoll, Charles F.....Grand Rapids  
 Jaracz, W. J.....Grand Rapids  
 Kelly, Robert E.....Grand Rapids  
 Kemmer, Thomas R.....Grand Rapids  
 Kendall, Eugene L.....Grand Rapids  
 Klaus, C. D.....Grand Rapids  
 Kniskern, P. W.....Grand Rapids  
 Koistra, Henry P.....Grand Rapids  
 Kremer, John.....Grand Rapids

Kreulen, H. J.....Grand Rapids  
 Krupp, C. G.....Grand Rapids  
 Laird, Robert G.....Grand Rapids  
 Lamb, George F.....Grand Rapids  
 Lanning, N. E.....Grand Rapids  
 Lanting, D. B.....Grand Rapids  
 Lass, E. H.....Grand Rapids  
 LeRoy, Simeon.....Grand Rapids  
 Loeffers, Harry.....Grand Rapids  
 Lyman, Wm. D.....Grand Rapids  
 MacPherson, Alex. G.....Grand Rapids  
 Marrin, M. M.....Grand Rapids  
 Marsh, J. P.....Grand Rapids  
 Maurits, Reuben.....Grand Rapids  
 McDonell, James A.....Lowell  
 McKenna, J. L.....Grand Rapids  
 McKinley, L. M.....Grand Rapids  
 McKee, John H.....Grand Rapids  
 Meengs, Jacob E.....Grand Rapids  
 Mehney, G. H.....Grand Rapids  
 Miller, Fred E.....Grand Rapids  
 Miller, J. Duane.....Grand Rapids  
 Miller, J. J.....Marne  
 Mitchell, H. C.....Grand Rapids  
 Mitchell, W. B.....Grand Rapids  
 Moen, Cornetta, G.....Grand Rapids  
 Moll, Arthur M.....Grand Rapids  
 Mollman, Arthur.....Grand Rapids  
 Moore, Vernon, M.....Grand Rapids  
 Mulder, J. D.....Grand Rapids  
 Murphy, M. J.....Grand Rapids  
 Nelson, A. R.....Grand Rapids  
 Nesbitt, E. N.....Grand Rapids  
 Noordewier, Albert.....Grand Rapids  
 Northouse, Peter B.....Grandville  
 Northrup, Wm.....Grand Rapids  
 Nyland, Albertus (Honorary).....Grand Rapids  
 Oliver, W. W.....Grand Rapids  
 Patterson, P. W.....Grand Rapids  
 Pedden, J. R.....Grand Rapids  
 Phillips, J. W.....Grand Rapids  
 Pyle, Henry J.....Grand Rapids  
 Ralph, L. Paul.....Grand Rapids  
 Rawson, A. P.....Grand Rapids  
 Reed, Torrance.....Grand Rapids  
 Riegerink, J. W.....Grand Rapids  
 Riley, G. L.....Grand Rapids  
 Roberts, Mortimer E.....Grand Rapids  
 Robinson, Harold.....Grand Rapids  
 Rogers, John R.....Grand Rapids

Roth, Emil M.....Grand Rapids  
 Schermerhorn, L. J.....Grand Rapids  
 Schnoor, E. W.....Grand Rapids  
 Sevensma, E. S.....Grand Rapids  
 Sevey, L. E.....Grand Rapids  
 Shepard, B. H.....Lowell  
 Shellman, Millard W.....Grand Rapids  
 Smith, A. B.....Grand Rapids  
 Smith, Edwin M.....Grand Rapids  
 Smith, R. Earle.....Grand Rapids  
 Smith, Ferris N.....Grand Rapids  
 Smith, Richard R.....Grand Rapids  
 Snapp, Carl F.....Grand Rapids  
 Snyder, Clarence.....Grand Rapids  
 Southwick, George H.....Grand Rapids  
 Stonehouse, G. G.....Grand Rapids  
 Stuart, G. J.....Grand Rapids  
 Sugg, Cullen E.....Grand Rapids  
 Swenson, H. C.....Grand Rapids  
 Ten Have, J.....Grand Rapids  
 Teusink, J. H.....Cedar Springs  
 Tidey, Marcus B.....Grand Rapids  
 Tolley, Edw. W.....Grand Rapids  
 Torgerson, Wm. R.....Grand Rapids  
 Van Bree, R. S.....Grand Rapids  
 Vanden Berg, Henry J.....Grand Rapids  
 Van Duine, H.....Bryon Center  
 Van Solkema, Arthur.....Grandville  
 Van Woerkom, Daniel.....Grand Rapids  
 Vann, Norman S.....Grand Rapids  
 Veldman, Harold E.....Grand Rapids  
 Veenboer, Wm. H.....Grand Rapids  
 Vis, William R.....Grand Rapids  
 Votey, Frank A.....Grand Rapids  
 Vyn, J. D.....Grand Rapids  
 Webb, Rowland.....Grand Rapids  
 Webster, G. W.....Grand Rapids  
 Wells, Merrill.....Grand Rapids  
 Wenger, A. V.....Grand Rapids  
 Wenger, John N.....Coopersville  
 Westrate, Paul.....Grand Rapids  
 Whalen, John M.....Grand Rapids  
 Whinery, Joseph B.....Grand Rapids  
 Whinery, J. F.....Grand Rapids  
 Willits, P. W.....Grand Rapids  
 Wolfe, H. C.....Grand Rapids  
 Woodburne, A. R.....Grand Rapids  
 Wright, John M.....Grand Rapids  
 Yegge, J. P.....Kent City

## Lapeer County

Berghorst, John.....Imlay City  
 Best, Herbert M.....Lapeer  
 Bishop, G. C.....Almont  
 Burley, David H.....Almont  
 Chapin, Clarence D.....Columbiaville

Crankshaw, D. W.....Imlay City  
 Dorland, Clark.....Lapeer  
 Hanna, Fred R.....Lapeer  
 Jackson, Carl C.....Imlay City  
 McBride, J. R.....North Branch

Merz, Henry G.....Lapeer  
 O'Brien, Daniel J.....Lapeer  
 Thomas, J. Orville.....North Branch  
 Tinker, F. A. (Emeritus).....Lapeer  
 Zemmer, H. B.....Lapeer

## Lenawee County

Abraham, A. O.....Hudson  
 Beebe, I. J.....Morenci  
 Blanchard, L. E.....Hudson  
 Bland, J. P.....Adrian  
 Case, C. W.....Onsted  
 Chase, Armetus W.....Adrian  
 Clafin, G. M.....Deerfield  
 Clark, A. D.....Adrian  
 Claxton, W. T.....Britton  
 Colbath, W. E.....Adrian  
 Growt, B. H.....Addison  
 Hall, George C.....Adrian  
 Hambly, S. B.....Onsted  
 Hammel, H. H.....Tecumseh

Hardy, P. B.....Tecumseh  
 Heffron, C. H.....Adrian  
 Heffron, Howard H.....Adrian  
 Helzerman, Ralph F.....Tecumseh  
 Hewes, A. B.....Adrian  
 Hornsby, W. B.....Clinton  
 Howland, F. A.....Adrian  
 Jewett, Wm. E., Jr.....Adrian  
 Lamley, Arthur E.....Blissfield  
 Lamley, Geo. H.....Blissfield  
 Lane, C. S.....Hudson  
 Loveland, Horace H.....Tecumseh  
 MacKenzie, W. S.....Adrian  
 McCue, F. J.....Hudson

Marsh, R. G. B.....Tecumseh  
 Miller, Perry L.....Adrian  
 Morden, Esli T.....Adrian  
 Murawa, V. J.....Deerfield  
 Patmos, Bernard.....Adrian  
 Peters, W. L.....Morenci  
 Raabe, E. C.....Morenci  
 Rogers, J. D.....Adrian  
 Spalding, A. L.....Hudson  
 Stafford, Leo. J.....Adrian  
 Tubbs, R. V.....Blissfield  
 Van Dusen, C. A.....Blissfield  
 Whitney, O.....Adrian  
 Wood, A. C.....Adrian

## Livingston County

Backe, John C.....Detroit  
 Brigham, Jeanette.....Howell  
 Burt, K. L.....Howell  
 Cameron, Duncan A.....Brighton  
 Glenn, Bernard H.....Fowlerville  
 Hayner, R. A.....Howell

Hill, Harold C.....Howell  
 Hendren, J. J.....Fowlerville  
 Huntington, H. G.....Howell  
 Laboe, Edward W.....Howell  
 Leslie, G. L.....Howell  
 Lojacono, Salvatore.....Howell

McGregor, Archie J.....Brighton  
 McIndoe, R. Bruce.....Howell  
 Mellus, H. P.....Brighton  
 Sigler, Hollis L.....Howell  
 Stephens, Duncan C.....Howell

## Luce County

Bohn, Frank P.....Newberry  
 Campbell, Earl H.....Newberry  
 Gibson, Robert E.....Newberry  
 Hart, Clarence D.....Newberry

Perry, Henry E.....Newberry  
 Pirmort, Wm. R., Jr.....Newberry  
 Rehn, Adolph T.....Newberry  
 Spinks, Robert E.....Newberry

Surrell, Mathew A.....Newberry  
 Swanson, George F.....Newberry  
 Toms, Charles B.....Newberry



### Macomb County

Allen, LeRoy K.....Roseville  
Bailey, R.....St. Clair Shores  
Banting, O. F.....Richmond  
Berry, Henry G.....Mt. Clemens  
Bower, A. B.....Armada  
Caster, E. Wilbur.....Mt. Clemens  
Croman, Joseph M., Jr..Mt. Clemens  
Croman, Joseph M., Sr..Mt. Clemens  
Curllett, J. E.....Roseville  
Dudzinski, E. J.....New Baltimore  
Engels, John A.....Richmond  
Fluemer, Oswald.....Mt. Clemens  
Greenshields, Robert.....Romeo

Hawley, R. E.....St. Clair Shores  
Heine, Austin W.....Mt. Clemens  
Kane, Wm. J.....Mt. Clemens  
Lane, W. D.....Romeo  
Lynch, Russell.....Centerline  
Meek, Charles.....New Baltimore  
Moore, G. F.....Mt. Clemens  
Norton, W. H.....Mt. Clemens  
Reichman, Joseph J.....Mt. Clemens  
Rivard, C. H.....St. Clair Shores  
Rothman, A. M.....East Detroit  
Reitzel, Rufus H.....Mt. Clemens  
Ruedisueli, C. A.....East Detroit

Russell, T. P.....Centerline  
Salot, R. F.....Mt. Clemens  
Scher, Joseph N.....Mt. Clemens  
Seaman, John.....New Haven  
Smith, M. C.....Mt. Clemens  
Sturin, Fred A.....St. Clair Shores  
Thompson, A. A.....Mt. Clemens  
Ullrich, R. W.....Mt. Clemens  
Wilde, M. M.....Warren  
Wiley, Bruce.....Utica  
Wiley, Herbert H.....Utica  
Wolfson, Victor H.....Mt. Clemens

### Manistee County

Bryan, Kathryn M.....Manistee  
Grant, C. L.....Manistee  
Fairbanks, Stephen.....Luther  
Hansen, E. C.....Manistee  
Jamieson, David A.....Arcadia

Konopa, John F.....Manistee  
Lewis, Lee A.....Manistee  
MacMullen, Harlen.....Manistee  
McKay, A. A.....Midland  
Miller, E. B.....Manistee

Mullenmeister, H. F.....Bear Lake  
Norconk, Ward H.....Bear Lake  
Oakcs, Ellery A.....Manistee  
Ramsdell, Homer A.....Manistee  
Switzer, Lars W.....Manistee

### Marquette-Alger Counties

Barnes, Haldor.....Munising  
Bennett, Arthur K.....Marquette  
Berry, Robert F.....Morgan Heights  
Bertucci, J. P.....Ishpeming  
Burke, R. A.....Palmer  
Casler, W. L.....Marquette  
Cooperstock, M.....Marquette  
Corcoran, W. A.....Ishpeming  
Cowan, Donald.....Marquette  
Crane, J. D.....Ishpeming  
Drury, Chas. P.....Marquette  
Elzinga, E. R.....Marquette  
Erickson, Arvid W.....Ishpeming

Felch, Theodore A. (Honorary).....  
.....Ishpeming  
Fennig, F. A.....Marquette  
Hanelin, H. A.....Marquette  
Hartt, P. P.....Ishpeming  
Hirwas, D. L.....Marquette  
Hornbogen, D. P.....Marquette  
James, R. Grant.....Marquette  
Keskey, Geo. I.....Marquette  
Lambert, W. C.....Marquette  
LeGolvan, C.....Marquette  
Lindquist, N. L.....Negaunee  
McCann, Neal J.....Ishpeming

McIntyre, D. R.....Negaunee  
Mudge, W. A.....Negaunee  
Niemi, O. I.....Marquette  
Picotte, Wilfrid S.....Ishpeming  
Robbins, Nelson J.....Negaunee  
Schutz, W. J.....Munising  
Serbst, Charles.....Gwinn  
Sicotte, Isiah.....Michigamme  
Swinton, A. L.....Marquette  
Talso, Jacob.....Ishpeming  
Vandeventer, Vivian H.....Ishpeming  
Van Riper, Paul.....Champion  
Wickstrom, G. W.....Munising

### Mason County

Blanchett, Victor J.....Custer  
Force, Wm. H.....Ludington  
Goulet, L. J.....Ludington  
Hoffman, Howard.....Ludington

Hunt, Ivan L.....Scottville  
Kirwan, Edward J.....Ludington  
Martin, Wm. S.....Ludington  
Paukstis, Charles.....Ludington

Spencer, C. M.....Scottville  
Switzer, G. O. (Honorary)..Ludington  
Taylor, W. H.....Ludington

### Mecosta-Osceola Counties

Bruggema, Jacob.....Evert  
Bunce, E. P.....Trufant  
Campbell, James B.....Big Rapids  
Chess, Leo F.....Reed City  
Clark, Chester.....Morley  
Franklin, Benjamin L.....Remus

Grieve, Glenn.....Big Rapids  
Igloe, Max C.....Big Rapids  
Inkovich, Paul.....Evert  
Kilmer, Paul B.....Reed City  
McIntyre, Donald.....Big Rapids  
McGrath, V. J.....Reed City

Peck, Louis K.....Barryton  
Power, C. J.....Remus  
Soper, Charles L.....Barryton  
Trenor, Thomas P.....Big Rapids  
White, J. A.....Morley  
Yeo, Gordon H.....Big Rapids

### Menominee County

Berg, Laurence A.....Menominee  
DeWane, F. J.....Menominee  
Flanagan, Clarence B.....Menominee  
Jones, Wm. S.....Menominee  
Kaye, J. T.....Menominee

Kerwell, K. C.....Stephenson  
Mason, Stephen C.....Menominee  
Peterson, A. R.....Daggett  
Sawbridge, Edward (Emeritus).....  
.....Stephenson

Schaen, Irvin.....Hermansville  
Scully, John C.....Menominee  
Setheny, Henry T.....Menominee  
Towey, J. W.....Powers

### Midland County

Beck, Frank K.....Coleman  
Gay, Harold H.....Midland  
Grewe, N. C.....Midland  
High, C. V.....Midland

Kazdan, Louis.....Midland  
McCallum, Charles.....Midland  
Maynard, W. A.....Coleman  
Meisel, E. H.....Midland  
Pike, Melvin H.....Midland

Place, Edwin H.....Midland  
Sherk, J. H.....Midland  
Sjolander, Gust.....Midland  
Towsley, W. D.....Midland

### Monroe County

Ames, Florence.....Monroe  
Barker, Vincent L.....Monroe  
Bond, W. W.....Monroe  
Cooper, E. M.....Rockwood  
Denman, Dean C.....Monroe  
Dusseau, S. V.....Erie  
English, R. I.....Temperance  
Ewing, R. T.....Monroe  
Gelhaus, Wm. J.....Monroe  
Glenn, Audrey.....Monroe

Golvinaux, C. J.....Monroe  
Graubner, F. L.....Monroe  
Heffernan, J. F.....Carleton  
Humphrey, J. A.....Monroe  
Hunter, M. A.....Monroe  
Landon, Herbert W.....Monroe  
Long, Edgar C.....Monroe  
Long, Sara.....Monroe  
McDonald, T. A.....Monroe  
McGeoch, R. W.....Monroe

McMillin, J. H.....Monroe  
Meck, H. L.....Dundee  
Newcomb, S. O.....Ida  
Parmelee, O. E.....Lambertville  
Reisig, A. H.....Monroe  
Siffer, J. J.....Monroe  
Smith, Wm. A.....Petersburg  
Stolpestad, C. T.....Monroe  
Tomlinson, Ledyard.....Newport  
Williams, Robert J.....Monroe

# ROSTER MICHIGAN STATE MEDICAL SOCIETY

## Muskegon County

Anderson, A. J.....Muskegon  
August, R. V.....Muskegon Heights  
Barnard, Helen.....Muskegon  
Bartlett, F. H.....Muskegon  
Beers, Charles.....Holton  
Bloom, C. J.....Muskegon  
Boonstra, Frank.....Muskegon  
Bowers, J. G.....Muskegon  
Boyd, D. R.....Muskegon  
Bradshaw, Park S.....Muskegon  
Cavanagh, R. G.....Muskegon  
Chapin, Wm. S.....Muskegon Heights  
Closz, H. F.....Muskegon  
Cohan, Sol G.....Muskegon  
Colignon, C. M.....Muskegon  
Collier, C. C.....Whitehall  
D'Alcorn, Ernest.....Muskegon  
Dasler, A. F.....Muskegon Heights  
Derezhinski, Clement F.....Muskegon  
Diskin, Frank.....Muskegon  
Dolfin, W. E.....Muskegon  
Douglas, Robert.....Muskegon  
Drummond, S. J.....Casnovia  
Durham, C. J.....Muskegon  
Eckerman, C. T.....Muskegon  
Egan, A. B.....Muskegon  
Fillingham, Enid.....Muskegon

Fleishman, C. B.....Muskegon  
Fleishman, Norman.....Muskegon  
Foss, Ed. O.....Muskegon  
Garber, F. W., Jr.....Muskegon  
Garland, J. O.....Muskegon  
Gillard, James.....Muskegon  
Goltz, Martha.....Montague  
Hagen, William A.....Muskegon  
Hannum, F. W.....Muskegon  
Harrington, A. F.....Muskegon  
Harrington, R. J.....Muskegon  
Hartwell, S. W.....Muskegon  
Heneveld, John.....Muskegon  
Holly, Leland E.....Muskegon  
Holmes, Roy H.....Muskegon  
Jackson, S. A.....Muskegon  
Kane, Thomas J.....Muskegon  
Keilin, Marie.....Muskegon  
Kerr, H. J.....Muskegon  
Kniskern, E. L.....Muskegon  
LeFevre, George L.....Muskegon  
LeFevre, Louis.....Muskegon  
LeFevre, William M.....Muskegon  
LaCore, O. M.....Muskegon Heights  
Lange, E. W.....Muskegon  
Lauretti, Emil.....Muskegon  
Laurin, V. S.....Muskegon

Loomis, John L.....Muskegon  
Loughery, H. B.....Muskegon  
Mandeville, C. B.....Muskegon  
Meengs, M. B.....Muskegon  
Medema, Paul E.....Muskegon  
Miller, Philip L.....Muskegon  
Morford, F. N.....Muskegon  
Morse, Bertram W.....Whitehall  
Mulligan, A. W.....Muskegon  
Oden, Constantine L.....Muskegon  
Olson, R. G.....Muskegon Heights  
Pangerl, Carl.....Muskegon Heights  
Pettis, Emmett.....Muskegon  
Powers, Lunette.....Muskegon  
Price, Leonard.....Muskegon  
Pyle, H. J.....Muskegon  
Risk, R. A.....Muskegon  
Risk, Robert D.....Muskegon  
Scholte, W.....Muskegon  
Spoor, A. A.....Muskegon  
Stone, Maxwell E.....Muskegon  
Swartout, W. C.....Muskegon  
Teifer, Charles A.....Muskegon  
Thieme, S. W.....Ravenna  
Thornton, E. S.....Muskegon  
Wilke, C. A.....Montague  
Wilson, P. S.....Muskegon

## Newaygo County

Barnum, W. H.....Fremont  
Deur, T. R.....Grant  
Geerlings, Lambert.....Fremont

Geerlings, Willis.....Fremont  
Lettinga, D.....Grant  
Moore, H. R.....Newaygo  
Post, Guy.....White Cloud

Stevens, S.....Bitley  
Stryker, O. D.....Fremont  
Tompsett, Arthur C.....Hesperia

## Northern Michigan

Armstrong, Robert B.....Charlevoix  
Burns, Dean C.....Petoskey  
Conkle, Guy C.....Boyne City  
Conway, Wm. S.....Petoskey  
Craddock, John.....Mackinaw City  
Dean, Carlton.....Charlevoix  
Duffie, Don H.....Central Lake  
Engle, Ralph D.....Petoskey  
Frank, Gilbert E.....Harbor Springs  
Grillet, F. F.....Alanson

Harrington, H. M.....East Jordan  
Huebner, A. C.....Onaway  
King, Geo. W.....Charlevoix  
Larson, W. E.....Levering  
Lashmet, Floyd H.....Petoskey  
MacGregor, J. G.....Boyne City  
Mast, W. H.....Petoskey  
Mayne, Frederick C.....Cheboygan  
McClure, Robert J.....Charlevoix  
McMillan, Fraley.....Charlevoix  
Miller, Samuel L.....Cheboygan

Monfort, Robert.....Onaway  
Palmer, Russell.....St. James  
Parks, W. H.....Petoskey  
Reed, Wilbur F. (Emeritus).....  
.....Cheboygan  
Rodgers, John.....Bellaire  
Saltonstall, Gilbert B.....Charlevoix  
Stringham, J. R.....Cheboygan  
Van Dellen, Jerrian.....Ellsworth  
Van Leuven, B. H.....Petoskey

## O.M.C.O.R.O. County

Beeby, R. J.....West Branch  
Clippert, C. G.....Grayling  
Crandell, C. H.....West Branch  
Egle, Joseph L.....Gaylord  
Ford, Ruey O.....Gaylord  
Harris, Levi A. (Emeritus).....Gaylord

Inman, J.....Kalkaska  
Jardine, Hugh.....West Branch  
Keyport, C. R.....Grayling  
Lee, F. W.....Fairview  
Martzowka, M. A.....Roscommon  
McDowell, A. S.....West Branch

McDowell, Douglas.....West Branch  
McKillop, G. L.....Gaylord  
Peckham, Richard.....Gaylord  
Sargent, L. E.....Kalkaska  
Stealey, Stanley.....Grayling  
Thompson, Sue H.....West Branch

## Oakland County

Abbott, V. C.....Pontiac  
Aschenbrenner, Z. R.....Farmington  
Bachelder, Frank S.....Pontiac  
Bachelor, John W.....Oxford  
Baker, Frederick A.....Pontiac  
Baker, Robert H.....Pontiac  
Barker, Howard B.....Pontiac  
Bauer, Ernest W.....Hazel Park  
Beck, O. O.....Birmingham  
Benning, C. H.....Peoria, Ill.  
Borland, Alexander.....Pontiac  
Burke, Chauncey G.....Pontiac  
Burt, F. J.....Holly  
Butler, Samuel A.....Pontiac  
Cameron, D. A.....Royal Oak  
Castell, Daniel G.....Pontiac  
Christie, J. W.....Pontiac  
Church, J. E.....Pontiac  
Cobb, Leon F.....Pontiac  
Cooper, Robert J.....Pontiac  
Crissman, H. C.....Ferndale  
Cudney, Ethan B.....Pontiac  
Dahlgren, Carl.....Keego Harbor  
Darling, C. G., Jr.....Pontiac  
Ekelund, C. T.....Pontiac  
Farnham, Lucius A.....Pontiac  
Ferris, Ralph G.....Birmingham  
Fitzpatrick, Francis.....Pontiac  
Fox, John W.....Pontiac  
Furlong, Harold A.....Pontiac  
Garipey, Bernard F.....Royal Oak  
Gatley, L. Warren.....Pontiac  
Gerls, Frank B.....Pontiac  
German, Frank D.....Pontiac  
Gordon, J. H.....Birmingham  
Grant, Wm. A.....Milford

Green, Wm. M.....Pontiac  
Hackett, Daniel J.....Pontiac  
Halsted, Lee H.....Farmington  
Hammer, Carl W.....Oxford  
Hammonds, E. E.....Birmingham  
Hathaway, Clarence L.....Lake Orion  
Hathaway, Wm.....Rochester  
Harvey, Campbell.....Pontiac  
Henry, Colonel R.....Ferndale  
Huffman, M. R.....Milford  
Howlett, E. V.....Pontiac  
Hoyt, D. F.....Pontiac  
Hume, T. W. K.....Auburn Heights  
Hurst, Daniel D.....Pleasant Ridge  
Jones, Morrell M.....Pontiac  
Kemp, W. Lloyd.....Birmingham  
Lambert, Alvin G.....Ferndale  
Lambie, John S.....Pontiac  
Lewis, Sol M.....Ferndale  
Lindsay, E. J.....Walled Lake  
Margraves, Edmund D.....Royal Oak  
Markley, John M.....Pontiac  
McConkie, J. P.....Birmingham  
McEvoy, Francis J.....Royal Oak  
McNeill, H. H.....Pontiac  
Mercer, Frank A.....Pontiac  
Mienke, Herman E.....Hazel Park  
Mijller, Raymond E.....Clarkston  
Mitchell, B. M.....Pontiac  
Mooney, C. A.....Ferndale  
Morrison, J. S.....Royal Oak  
Neafie, Chas. A.....Pontiac  
Olsen, Richard E.....Pontiac  
Pauli, Theodore H.....Pontiac  
Pool, H. H.....Pontiac  
Porritt, Ross J.....Pontiac

Raynale, George P.....Birmingham  
Reid, F. T.....Clawson  
Riker, Aaron D.....Pontiac  
Roehm, Harold R.....Birmingham  
Rooks, Wendell H.....Pontiac  
Russell, Vincent.....Royal Oak  
St. John, Harold A.....Pontiac  
Seaborn, A. J.....Royal Oak  
Schoenfeld, John D.....Birmingham  
Sheffield, L. C.....Pontiac  
Sherman, G. A.....Pontiac  
Sibley, H. A.....Pontiac  
Simpson, E. K.....Pontiac  
Spears, M. L.....Pontiac  
Spencer, Lloyd H.....Royal Oak  
Spoehr, Eugene L.....Ferndale  
Spohn, Earl.....Royal Oak  
Stahl, Harold E.....Oxford  
Stanley, Wm. F.....Ferndale  
Starker, Clarence T.....Pontiac  
Steinberg, Norman.....Royal Oak  
Stolpman, A. K.....Birmingham  
Strain, C. S.....Rochester  
Sutherland, Clark J.....Clarkston  
Sutton, Palmer E.....Royal Oak  
Terry, Stuart.....Pontiac  
Tuck, R. G.....Pontiac  
Wagley, P. V.....Pontiac  
Wagner, Ruth E.....Royal Oak  
Watson, Arthur M.....Lake Orion  
Watson, Thomas Y.....Birmingham  
Wiers, W. W.....Royal Oak  
Williams, Hugh W.....Pontiac  
Yoh, Harry B.....Pontiac  
Young, Arthur R.....Pontiac



Oceana County

Day, Clinton.....Hart  
Hayton, A. R.....Shelby  
Heard, William.....Pentwater

Heysett, N. W.....Hart  
Jensen, Viggo.....Shelby  
Lemke, Walter M.....Shelby  
Munger, L. P.....Hart

Nicholson, John H.....Hart  
Reetz, Fred A.....Shelby  
Wood, Merle G.....Hart

Ontonagon County

Bender, Jesse L.....Mass  
Corkill, C. C.....Ontonagon  
Evans, Edwin J.....Ontonagon

Hogue, H. B.....Ewen  
McHugh, Frank W.....Ontonagon  
Rubinfeld, S. H.....Ontonagon

Strong, W. F.....Ontonagon  
Whiteshield, C. F.....Trout Creek

Ottawa County

Beernink, E. H.....Grand Haven  
Bloemendaal, D. C.....Zeeland  
Bloemendaal, W. B.....Grand Haven  
Boone, Cornelius E.....Zeeland  
Bos, G. D.....Holland  
Clark, N. H.....Holland  
DeVries, H. C.....Holland  
DeWitt, S. L.....Grand Haven  
Harms, H. P.....Holland  
House, M. E.....Holland

Huizinga, John G.....Holland  
Irvin, H. C.....Holland  
Kemmer, Gerrit.....Zeeland  
Kools, Wm. C.....Holland  
Leenhouts, Abraham.....Holland  
Long, C. E.....Grand Haven  
Mulder, C. D.....Spring Lake  
Nichols, Rudolph H.....Holland  
Presley, Wm. J.....Grand Haven  
Stickley, A. E.....Coopersville  
Tappan, Wm. M.....Holland

Ten Have, Ralph.....Grand Haven  
Timmerman, E. C.....Coopersville  
Ver Duin, J.....Grand Haven  
Van Der Berg, E.....Holland  
Van der Velde, O.....Holland  
Wells, Kenneth.....Spring Lake  
Westrate, William.....Holland  
Wiersma, Silas C.....Hudsonville  
Winters, John K.....Holland  
Winters, Wm. G.....Holland

Saginaw County

Ackerman, G. L.....Saginaw  
Anderson, W. K.....Saginaw  
Bagley, U. S.....Saginaw  
Bagshaw, David E.....Saginaw  
Beckwith, Bertram H.....Saginaw  
Berberovitch, T. F.....Saginaw  
Bishop, H. M.....Saginaw  
Brender, Fred P.....Frankenmuth  
Brock, W. H.....Saginaw  
Butler, M. G.....Saginaw  
Button, A. C.....Saginaw  
Cady, F. J.....Saginaw  
Cameron, Allen K.....Saginaw  
Campbell, L. A.....Saginaw  
Catizone, R. J.....Merrill  
Clark, Wilbert B.....Saginaw  
Claytor, Archer A.....Saginaw  
Cortopassi, Andre.....Saginaw  
Durman, Donald.....Saginaw  
Ely, C. W.....Saginaw  
English, William F.....Saginaw  
Ernst, Arthur R.....Saginaw  
Eymmer, Esther.....Saginaw  
Fleschner, Thomas E.....Birch Run  
Freeman, Frederick W.....Saginaw  
Galsterer, E. C.....Saginaw  
Goman, Louis D.....Saginaw  
Grigg, Arthur.....Saginaw  
Hand, Eugene.....Saginaw  
Harvie, L. C.....Saginaw  
Helmkamp, Herbert O.....Saginaw  
Hester, E. G.....Saginaw

Hill, Victor L.....Saginaw  
Hohn, F. J.....Saginaw  
Imerman, Harold M.....Saginaw  
Jaenichen, R.....Saginaw  
James, J. W.....Saginaw  
Jiroch, R. S.....Saginaw  
Jordan, Leo A.....Saginaw  
Kahn, Paul.....Frankenmuth  
Keller, S. S.....Saginaw  
Kemp, J.....Saginaw  
Kempson, R. M.....Saginaw  
Kirchgerog, Clemens G.....Frankenmuth  
Kleekamp, H.....Saginaw  
Knott, Harriet.....Saginaw  
Leitch, Arthur E.....Saginaw  
Ling, Ernest M.....Hemlock  
Lohr, O. W.....Saginaw  
Longstreet, Martha L.....Saginaw  
Luger, F. E.....Saginaw  
MacKinnon, Edwin D.....Saginaw  
Markey, Joseph P.....Saginaw  
Martzowka, Wm. P.....Saginaw  
Maurer, John A.....Saginaw  
McClinton, N. F.....Saginaw  
McGregor, R.....Saginaw  
McKinney, Alex R.....Saginaw  
McLandress, Joshua A.....Saginaw  
McMeekin, James W.....Saginaw  
Meyer, Henry J.....Saginaw  
Moon, A. R.....Saginaw  
Morris, Keith M.....Saginaw  
Mudd, Richard D.....Saginaw

Murphy, Albert P.....Saginaw  
Murray, Charles R.....Saginaw  
Novy, F. O.....Saginaw  
O'Reilly, Wm. J.....Saginaw  
Ostrander, Frank W.....Freeland  
Pietz, Frederick.....Saginaw  
Pillsbury, Edw. A.....Frankenmuth  
Poole, Frank A.....Saginaw  
Potvin, Clifford D.....Merrill  
Richter, Emil P. W.....Saginaw  
Rosenberg, Robert.....Saginaw  
Rubin, H.....Saginaw  
Ryan, M. D.....Saginaw  
Ryan, R. S.....Saginaw  
Sample, Chester H. (Honorary).....Saginaw  
Sample, J. T.....Saginaw  
Sargent, D. V.....Saginaw  
Schaiberger, Elmer.....Saginaw  
Sheldon, S.....Saginaw  
Slack, Walter K.....Saginaw  
Stander, A. C.....Saginaw  
Thomas, Dale.....Saginaw  
Tiedke, G. E.....Saginaw  
Toshach, C. E.....Saginaw  
Wallace, H. C.....Saginaw  
Wheeler, Dorothy.....Saginaw  
Wilson, H. Roy.....Saginaw  
Wixted, John F.....Chesaning  
Wixted, Julia L.....Chesaning  
Yntema, S.....Saginaw

St. Clair County

Armsbury, A. B.....Marine City  
Atkinson, J. M.....Port Huron  
Attridge, J. A.....Port Huron  
Battley, J. C. Sinclair.....Port Huron  
Borden, C. L.....Yale  
Boughner, W. H.....Algonac  
Bovee, M. E.....Port Huron  
Brush, Howard O.....Port Huron  
Burke, Ralph M.....Port Huron  
Burley, Jacob H.....Port Huron  
Callery, A. L.....Port Huron  
Campbell, R. H.....St. Clair  
Carney, F. V.....St. Clair  
Cooper, T. H.....Port Huron  
DeGurse, T. E.....Marine City  
Derck, W. P.....Marysville

Engelman, A. A.....St. Clair  
Fraser, Robert C.....Port Huron  
Heavenrich, T. F.....Port Huron  
Holcomb, R. J.....Marine City  
Johnson, Howard R.....B. shop Hill, Ill.  
Kest, Geo. M.....Port Huron  
LeGalley, K. B.....Port Huron  
Licker, R. R.....Port Huron  
Ludwig, F. E.....Port Huron  
McCue, Crystal C.....Goodells  
MacKenzie, Alexander J.....Port Huron  
MacPherson, C. A.....St. Clair  
Martin, C. S.....Port Huron  
McColl, D. J.....Port Huron  
McColl, Neil J.....Port Huron  
Meredith, E. W.....Port Huron  
Patterson, D. W.....Port Huron

Pollock, Donald A.....Yale  
Reynolds, Annie E.....Port Huron  
Ryerson, W. W.....Port Huron  
Schaefer, W. A.....Port Huron  
Sites, E. C.....Port Huron  
Smith, Reginald.....Port Huron  
Thomas, C. F.....Port Huron  
Treadgold, Douglas.....Port Huron  
Vroman, M. E.....Port Huron  
Waltz, J. F.....Capac  
Ware, John R.....Port Huron  
Wass, Henry C.....St. Clair  
Waters, George.....Port Huron  
Wellman, Joseph E.....Port Huron  
Wight, William G.....Yale  
Zemmer, Adrian L.....Port Huron

St. Joseph County

Buell, Martin.....Sturgis  
Fiegel, S. A.....Sturgis  
Fortner, R. J.....Three Rivers  
Hoekman, Aben.....Constantine  
Kane, David M.....Sturgis

Miller, C. G.....Sturgis  
Parrish, Marion F.....Sturgis  
Rice, John W.....Sturgis  
Shaw, G. D.....Mendon  
Sheldon, J. P.....Sturgis  
Slote, L. K.....Constantine

Springer, R. A.....Centerville  
Sweetland, G. J.....Constantine  
Weir, D. C.....Three Rivers  
Wilkerson, Nina C.....Sturgis  
Ziment, R. D.....Constantine

Schoolcraft County

Broberg, Gail.....Manistique  
Fyvie, James.....Manistique

Ross, Donald.....Manistique  
Shaw, George A.....Manistique

Tucker, A. R.....Manistique

# ROSTER MICHIGAN STATE MEDICAL SOCIETY

## Shiawassee County

Alexander, Reuben G.....Laingsburg  
Arnold, Alfred L., Jr.....Owosso  
Arnold, A. L., Sr. (Emeritus)..Owosso  
Bates, L. F.....Durand  
Brandel, J. M.....Owosso  
Brown, Richard J.....Owosso  
Buzzard, Walter D.....Chesaning  
Carney, Edward J.....Durand  
Cramer, Geo. L. G.....Owosso  
Crane, C. A.....Corunna  
Fillinger, W. B.....Ovid

Greene, I. W.....Owosso  
Haviland, James J.....Owosso  
Hume, Arthur M. (Emeritus)..Owosso  
Hume, Harold A.....Owosso  
Janci, Julius.....Owosso  
Linden, V. E.....Durand  
McElmurry, N. K.....Perry  
McKnight, E. R.....Owosso  
Parker, W. T.....Owosso  
Pochert, R. C.....Owosso  
Richards, C. J.....Durand

Sackrider, Geo. P.....Owosso  
Shepherd, W. F.....Owosso  
Slagh, E. M.....Elsie  
Soule, Glenn T.....Henderson  
Taylor, W. M.....Ovid  
Wade, G. B.....Laingsburg  
Ward, Walter E. (Emeritus)..Owosso  
Watts, Fred A.....Owosso  
Weinkauff, W. F.....Corunna  
Wilcox, Anna L.....Owosso  
Wilcox, C. M.....Owosso

## Tuscola County

Barbour, Harry A.....Mayville  
Bates, George.....Kingston  
Cook, Raymond.....Akron  
Dickerson, W. W.....Wahjamega  
Dixon, Robert L.....Wahjamega  
Donahue, H. Theron.....Cass City  
Gugino, Frank J.....Reese  
Handy, John E. (Emeritus)....Caro  
Hoffman, T. E.....Vassar  
Howlett, Robert R.....Caro

Johnson, O. G.....Mayville  
Kaven, G. H.....Unionville  
Kralick, Louise C.....Wahjamega  
MacRae, L. D.....Gagetown  
Maurer, J. G.....Reese  
McCoy, I. D.....Bad Axe  
Merrill, Elmer H.....Caro  
Morris, Frank L.....Cass City  
Petrie, W. P.....Caro  
Ross, Alexander T.....Wahjamega

Rundell, Annie Stevens.....Vassar  
Ruskin, D. B.....Fairgrove  
Salot, D. G.....Millington  
Savage, Lloyd L.....Caro  
Spohn, U. G.....Fairgrove  
Starmann, Bernard H.....Cass City  
Swanson, Ewald C.....Vassar  
Vatz, Jack A.....Millington  
Vail, Harry F.....Unionville  
Von Renner, Otto.....Vassar

## Washtenaw County

Alexander, John.....Ann Arbor  
Adams, James F.....Ann Arbor  
Badgley, Carl.....Ann Arbor  
Ballmer, Robert S.....Ann Arbor  
Barker, Paul.....Ann Arbor  
Barnwell, John.....Ann Arbor  
Barr, A. S.....Ann Arbor  
Barss, Harold D.....Ypsilanti  
Bartlett, R. M.....Ann Arbor  
Bassow, Paul.....Ann Arbor  
Beebe, Hugh M.....Ann Arbor  
Bell, Margaret.....Ann Arbor  
Belote, G. H.....Ann Arbor  
Belser, Walter.....Ann Arbor  
Bigelow, Robert B.....Boston, Mass.  
Boyd, David A.....Ann Arbor  
Brace, Wm. M.....Ann Arbor  
Braden, Spencer.....Ann Arbor  
Breakey, Jas. R.....Ypsilanti  
Brinkman, Harry.....Ann Arbor  
Brown, Phillip.....Ypsilanti  
Brown, Willis E.....Ann Arbor  
Brownell, Durwin.....Ann Arbor  
Bruce, James D.....Ann Arbor  
Camp, Carl Dudley.....Ann Arbor  
Carpenter, L. C.....Ann Arbor  
Clements, Glenn T.....Ann Arbor  
Coller, F. A.....Ann Arbor  
Combs, Arnold B.....Ann Arbor  
Conn, Jerome W.....Ann Arbor  
Cowie, D. M.....Ann Arbor  
Cummings, H. H.....Ann Arbor  
Curtis, A. C.....Ann Arbor  
Davis, Marion I.....Ann Arbor  
DeJong, Russell.....Ann Arbor  
DeTar, John S.....Milan  
Dirksee, Paul.....Ann Arbor  
Donaldson, S. W.....Ann Arbor  
Durfee, M. L.....Ann Arbor  
Emerson, Herbert W.....Ann Arbor  
Failing, Joseph H.....Ann Arbor  
Field, Henry, Jr.....Ann Arbor  
Forsythe, W. E.....Ann Arbor  
Fralick, F. Bruce.....Ann Arbor  
Freyberg, Richard H.....Ann Arbor  
Frye, Carl H.....Ann Arbor  
Furstenberg, Albert C.....Ann Arbor  
Ganzhorn, Edwin.....Ann Arbor  
Gardiner, Sprague.....Ann Arbor  
Gates, John L.....Ann Arbor  
Georg, Conrad.....Ann Arbor  
Gordon, Vida H.....Ann Arbor  
Grosh, L. C.....Ypsilanti

Gulde, Andros.....Chelsea  
Gump, M. E.....Ann Arbor  
Hannum, M. R.....Milan  
Haight, Cameron.....Ann Arbor  
Harris, Bradley M.....Ypsilanti  
Harris, H. W.....Ann Arbor  
Hauser, I. J.....Ann Arbor  
Haynes, Harley A.....Ann Arbor  
Healey, Claire E.....Ann Arbor  
Himler, Leonard E.....Ann Arbor  
Hodges, Fred J.....Ann Arbor  
Howard, S. C.....Ann Arbor  
Inch, G. F.....Ypsilanti  
Isaacs, Raphael.....Ann Arbor  
Jackson, Howard C.....Ann Arbor  
Jimenez, Buenaventura.....Ann Arbor  
Johnson, Lester J.....Ann Arbor  
Johnson, V. C.....Ann Arbor  
Johnston, F. D.....Ann Arbor  
Kahn, Edgar A.....Ann Arbor  
Kemper, J. W.....Ann Arbor  
Kleinschmidt, Earl E.....Ann Arbor  
Kleinschmidt, Gladys.....Ann Arbor  
Kline, E. M.....Ann Arbor  
Klingman, Theophil.....Ann Arbor  
Knoll, Leo.....Ann Arbor  
Kretschmar, N. R.....Ann Arbor  
LaFever, Sidney L.....Ann Arbor  
Langford, Theron S.....Ann Arbor  
Law, John L.....Ann Arbor  
Lathrop, F. D.....Ann Arbor  
Lichty, Dorman E.....Ann Arbor  
Lilly, Coral A.....Ann Arbor  
MacKenzie, Aileen McQ.....Ypsilanti  
Malcolm, Karl D.....Ann Arbor  
Marshall, Mark.....Ann Arbor  
Maxwell, J. H.....Ann Arbor  
McEachern, Thomas H.....Ann Arbor  
McGarvey, M. R.....Ann Arbor  
Metzger, Ida.....Ypsilanti  
Miller, Harold.....Saline  
Miller, Norman F.....Ann Arbor  
Muehlig, Geo. F.....Ann Arbor  
Myers, Dean W.....Ann Arbor  
Nesbit, Reed M.....Ann Arbor  
Newburgh, L. H.....Ann Arbor  
Oliphant, L. W.....Ann Arbor  
Parnall, Christopher.....Ann Arbor  
Paton, Thomas W.....Ypsilanti  
Patterson, Ralph M.....Ann Arbor  
Patton, Robert J.....Ann Arbor  
Peck, Willis S.....Ann Arbor

Peet, Max.....Ann Arbor  
Pillsbury, Charles B.....Ypsilanti  
Peterson, Reuben (Emeritus).....Duxbury, Mass.  
Pollard, H. M.....Ann Arbor  
Prout, Gordon H. J.....Saline  
Ransom, Henry.....Ann Arbor  
Raphael, Theophile.....Ann Arbor  
Ratcliff, R. K.....Ann Arbor  
Riecker, H. H.....Ann Arbor  
Riggs, H. W.....Ann Arbor  
Ross, Howard.....Ann Arbor  
Sacks, Wilma.....Ann Arbor  
Schnute, Louise F.....Ann Arbor  
Schumacker, W. E.....Ann Arbor  
Sheldon, John M.....Ann Arbor  
Sink, Emory W.....Ann Arbor  
Smalley, Marianna.....Ann Arbor  
Smith, Donald S.....Ann Arbor  
Smith, N. M.....Ann Arbor  
Snow, Glenadine.....Ypsilanti  
Snow, James S.....Ann Arbor  
Solis, Jeanne C.....Ann Arbor  
Steiner, L. G.....Ann Arbor  
Stryker, Homer H.....Ann Arbor  
Sturgis, Cyrus C.....Ann Arbor  
Sundwall, John.....Ann Arbor  
Teed, Reed Wallace.....Ann Arbor  
Teitelbaum, Myer.....Ann Arbor  
Thieme, M. Thurston.....Ann Arbor  
Todd, Oliver E.....Ann Arbor  
Tolan, Jack F.....Ann Arbor  
Towsley, Harry A.....Ann Arbor  
Vander Slice, David.....Ann Arbor  
Wager, Spencer.....Ann Arbor  
Waggoner, R. W.....Ann Arbor  
Waldron, Fred R.....Ann Arbor  
Wallace, J. B.....Saline  
Wanstrom, Ruth.....Ann Arbor  
Washburne, Charles L.....Ann Arbor  
Wassell, G. K.....Ann Arbor  
Weller, C. V.....Ann Arbor  
Wessinger, J. A. (Emeritus).....Ann Arbor  
Wile, Udo J.....Ann Arbor  
Wilson, Frank N.....Ann Arbor  
Winslow, Sherwood B.....Ann Arbor  
Wisdom, Inez.....Ann Arbor  
Worth, M. H.....Ypsilanti  
Wright, Wm. J.....Ypsilanti  
Wylie, Wm. C.....Dexter  
Yoder, O. R.....Ypsilanti

## Wayne County

Aaron, Charles D.....Detroit  
Abrams, Harry M.....Detroit  
Adclson, Sydney L.....Detroit  
Adler, Leopold.....Detroit  
Akins, Jacob.....Detroit  
Agnelly, E. J.....Detroit  
Agnew, George H.....Detroit  
Albrecht, Herman F.....Detroit  
Aldrich, E. G.....Detroit  
Allen, N. M.....Detroit  
Alles, R. W.....Detroit  
Alford, E. S.....Detroit  
Allen, C. I.....Detroit  
Allen, R. B.....Detroit  
Allison, Frank B.....Detroit

Altman, Raphael.....Detroit  
Altshuler, S. S.....Detroit  
Amberg, Emil.....Detroit  
Ames, Chester C.....Detroit  
Amolsch, Arthur L.....Detroit  
Amos, Thomas G.....Detroit  
Anderson, Bruce.....Detroit  
Andries, J. H.....Detroit  
Andries, R. C.....Detroit  
Ankley, J. W.....Detroit  
Anslow, Robert.....Detroit  
Appel, P. R.....Detroit  
Appelman, H. B.....Detroit  
Armstrong, Arthur G.....Detroit  
Armstrong, O. S. (Emeritus)..Detroit

Arnold, Effic.....Detroit  
Aronstam, N. E.....Detroit  
Ascher, Meyer S.....Detroit  
Ashe, S. R.....Detroit  
Ashley, L. Byron.....Detroit  
Asselin, J. L.....Detroit  
Athay, Roland M.....Detroit  
August, H. E.....Detroit  
Babcock, Kenneth.....Detroit  
Babcock, Myra.....Detroit  
Babcock, W. L.....Detroit  
Babcock, W. W.....Detroit  
Bach, Walter F.....Detroit  
Bacon, V. A.....Detroit  
Baer, Raymond B.....Detroit



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Bailey, Carl C.....	Detroit	Brunk, A. S.....	Detroit	Cooley, Thomas B.....	Detroit
Bailey, Don A.....	Detroit	Brunk, Clifford F.....	Detroit	Cooper, Edmond L. J.....	Detroit
Bailey, Louis J.....	Detroit	Brunke, B. B.....	Detroit	Cope, H. E.....	Detroit
Baker, Clarence.....	Detroit	Bryce, John D.....	Detroit	Corbett, John J.....	Detroit
Baker, Howard B.....	Detroit	Buchanan, W. Paul.....	Detroit	Corbeille, Catherine.....	Detroit
Balaga, F. T.....	Detroit	Buell, Charles E.....	Detroit	Costello, Russell.....	Detroit
Balcerski, M. A.....	Detroit	Buesser, Frederick G.....	Detroit	Cothran, Robert M.....	Detroit
Ballard, Charles S.....	Detroit	Bullock, Earl S.....	Detroit	Cotruro, L. D.....	Detroit
Balser, Charles W.....	Detroit	Burgess, Charles M.....	Detroit	Cowan, A. L.....	Detroit
Baltz, James I.....	Detroit	Buller, H. L.....	Detroit	Cowan, Robert L.....	Detroit
Barnes, D. J.....	Detroit	Burgess, Jay M.....	Detroit	Cowan, Wilfred.....	Detroit
Barnett, S. E.....	Detroit	Burnside, Howard B.....	Detroit	Crawford, Albert S.....	Detroit
Barrett, W. D.....	Detroit	Burns, Robert T.....	Detroit	Cree, Walter J. (Emeritus).....	Detroit
Bartemeier, Leo H.....	Detroit	Burnstine, J. Y.....	Detroit	Crews, Thomas H.....	Detroit
Barton, J. R.....	Detroit	Burnstine, P. P.....	Detroit	Croll, L. J.....	Detroit
Bates, G. S.....	Detroit	Burr, George C.....	Detroit	Crossen, Henry.....	Detroit
Bauer, L. E.....	Detroit	Buss, J. A.....	Detroit	Croushore, James E.....	Detroit
Baugh, R. H.....	Detroit	Butler, H. J.....	Detroit	Cruikshank, Alexander.....	Detroit
Baumann, Walter.....	Detroit	Butler, L. H.....	Detroit	Cumming, Robert E.....	Detroit
Baumgarten, E. C.....	Detroit	Butler, Volney J.....	Detroit	Curry, F. S.....	Detroit
Baumer, Moe.....	Detroit	Buttrum, E. J.....	Detroit	Curtis, Frank E.....	Detroit
Beach, Watson.....	Detroit	Byington, G. M.....	Detroit	Cushman, H. P.....	Detroit
Beame, A. Duane.....	Detroit	Byrd, Cloyd R.....	Detroit	Dail, O. C.....	Detroit
Beaton, Colin.....	Detroit	Cadieux, Henry W.....	Detroit	Dana, H. M.....	Detroit
Beattie, Robert.....	Detroit	Caldwell, J. E.....	Detroit	Danforth, James C.....	Detroit
Beatty, S. M.....	Detroit	Calkins, H. N.....	Detroit	Danforth, Mortimer E.....	Detroit
Beaver, Donald C.....	Detroit	Callaghan, T. T.....	Detroit	Daniels, Lewis E.....	Detroit
Becker, Joseph W.....	Detroit	Campau, Geo. H.....	Detroit	Darling, Milton.....	Detroit
Becklein, C. L.....	Detroit	Campbell, Don M.....	Detroit	Darpin, Peter H.....	Detroit
Bedell, A.....	Detroit	Campbell, Duncan.....	Detroit	Davidow, David M.....	Detroit
Beery, Wm. J.....	Detroit	Campbell, Mary B.....	Detroit	Davies, Thomas S.....	Detroit
Begle, H. L.....	Detroit	Campbell, M. D.....	Detroit	Davis, C. R.....	Detroit
Behn, Claude W.....	Detroit	Candler, Clarence L.....	Detroit	Davis, Egbert F.....	Detroit
Beigler, S. K.....	Detroit	Canter, G. E.....	Detroit	Davis, Windsor.....	Detroit
Belanger, Henry.....	Detroit	Caplan, Leslie.....	Detroit	Davis, James E.....	Detroit
Belknap, C. H.....	Detroit	Carleton, L. H.....	Detroit	Davidson, Harry O.....	Detroit
Bell, J. Kenner.....	Detroit	Carlucci, Peter F.....	Detroit	Dawson, F. E.....	Detroit
Belsey, Joseph P.....	Detroit	Carmichael, E. K.....	Detroit	Day, J. Claude.....	Detroit
Benjamin, C. C.....	Detroit	Carpenter, G. B.....	Detroit	Defnet, W. A.....	Detroit
Bennett, Harry B.....	Detroit	Carr, J. G.....	Detroit	DeKleine, E. Hoyt.....	Detroit
Benson, C. D.....	Detroit	Carroll, E. H.....	Detroit	Dempster, James H.....	Detroit
Benson, Davis A.....	Detroit	Carroll, Leona B.....	Detroit	DeNike, A. J.....	Detroit
Benson, Roland R.....	Detroit	Carson, Herman J.....	Detroit	Dennis, George.....	Detroit
Bentley, Neil I.....	Detroit	Carstens, Henry R.....	Detroit	DeNosauquo, Norman.....	Detroit
Berent, Morris S.....	Detroit	Carter, J. M.....	Detroit	DeWaele, P. L.....	Detroit
Berge, C. A.....	Detroit	Cassidy, W. J.....	Detroit	DeWitt, A. S.....	Detroit
Berke, Sydney S.....	Detroit	Castrop, C. W.....	Detroit	Dibble, H. F.....	Detroit
Berkowitz, Wm. E.....	Detroit	Cathcart, Edward.....	Detroit	Dickson, B. R.....	Detroit
Berman, Robert.....	Detroit	Catherwood, A. E.....	Detroit	Diebel, N. W.....	Detroit
Berman, Harry.....	Detroit	Caughey, M. D.....	Detroit	Diebel, W. H.....	Detroit
Berman, Sidney.....	Detroit	Cetlinski, C. A.....	Detroit	Dill, Hugh L.....	Detroit
Bernard, Walter G.....	Detroit	Chalat, Jacob H.....	Detroit	Dill, J. L.....	Detroit
Bernath, G. J.....	Detroit	Chance, J. H.....	Detroit	Dixon, R. S.....	Detroit
Bernbaum, B.....	Detroit	Chapman, A. L.....	Detroit	Dodds, John C.....	Detroit
Bernfield, Martin A.....	Detroit	Chapnick, H. A.....	Detroit	Dodehoff, C. F.....	Detroit
Bernstein, Samuel S.....	Detroit	Chase, C. H.....	Detroit	Dodehoff, P. C.....	Detroit
Bernstine, Albert E.....	Detroit	Chatel, Arthur N.....	Detroit	Doddrill, F. D.....	Detroit
Bertram, F. B.....	Detroit	Chene, George.....	Detroit	Domalski, Casimir.....	Detroit
Best, T. H. E.....	Detroit	Chenik, Ferdinand.....	Detroit	Donald, Wm. M.....	Detroit
Bicknell, Edgar A.....	Detroit	Chester, W. P.....	Detroit	Donovan, Daniel R., Jr.....	Detroit
Bicknell, Frank B.....	Detroit	Chittenden, G. E.....	Detroit	Doty, A. G.....	Detroit
Bicknell, Nathan J.....	Detroit	Chostner, G. C.....	Detroit	Doty, Chester A.....	Detroit
Biddle, Andrew P. (Emeritus).....	Detroit	Christensen, C. A.....	Detroit	Doub, Howard P.....	Detroit
Birch, John R.....	Detroit	Christopoulos, D. G.....	Detroit	Douglas, Bruce H.....	Detroit
Black, Perry S.....	Detroit	Chrouch, Laurence A.....	Detroit	Douglas, Clair L.....	Detroit
Blanchard, F. N.....	Detroit	Ciprian, Joseph E.....	Detroit	Dovitz, Benjamin W.....	Detroit
Birkelo, Carl C.....	Detroit	Clark, Ben W.....	Detroit	Dowdle, Edward.....	Detroit
Blain, Alexander W.....	Detroit	Clark, C. M.....	Detroit	Dowling, Harvey E.....	Detroit
Blashill, James B.....	Detroit	Clark, D. R.....	Detroit	Dowling, Pearl Christie.....	Detroit
Bleier, Joseph.....	Detroit	Clark, Donald V.....	Detroit	Downer, Ira G.....	Detroit
Bloch, Abraham.....	Detroit	Clark, Harold E.....	Detroit	Doyle, George H.....	Detroit
Bloom, Arthur E.....	Detroit	Clark, Harry G.....	Detroit	Drake, J. J.....	Detroit
Blodgett, Wm. E.....	Detroit	Clark, H. L.....	Detroit	Drescher, G. A.....	Detroit
Bloomer, Earl.....	Detroit	Clark, R. L.....	Detroit	Drolshagen, E. A.....	Detroit
Bohn, Stephen.....	Detroit	Clarke, E. A.....	Detroit	Droock, V.....	Detroit
Boland, J. R.....	Detroit	Clarke, Geo. L.....	Detroit	Droste, A. T.....	Detroit
Boles, A. E.....	Detroit	Clarke, Niles A.....	Detroit	Drummond, Donald L.....	Detroit
Bovill, E. G.....	Detroit	Clarke, Norman E.....	Detroit	DuBois, Paul W.....	Detroit
Bowers, Leo J.....	Detroit	Clifford, Charles H.....	Detroit	Dubnové, Aaron.....	Detroit
Bowman, F. E.....	Detroit	Clifford, T. P.....	Detroit	Dubpernell, Karl.....	Detroit
Brachman, D. S.....	Detroit	Clinton, Wm. R.....	Detroit	Dubpernell, Martin S.....	Detroit
Bradfield, A.....	Detroit	Cobane, John.....	Detroit	Duffy, Edward A.....	Detroit
Bradshaw, Wm. H.....	Detroit	Cochrane, E. G.....	Detroit	Dundas, Edward M.....	Detroit
Braley, W. N.....	Detroit	Cohn, Daniel E.....	Detroit	Dunlap, Henry A.....	Detroit
Bramigk, Fritz W.....	Detroit	Cohoe, Don A.....	Detroit	Dunn, Cornelius E.....	Detroit
Brand, Benjamin.....	Detroit	Cole, Fred H.....	Detroit	Dupont, R. S.....	Detroit
Branch, H. E.....	Detroit	Cole, James E.....	Detroit	Dutchess, Charles E.....	Detroit
Braun, Lionel.....	Detroit	Cole, Wyman C. C.....	Detroit	Dwaihy, Paul.....	Detroit
Brennan, Thomas J.....	Detroit	Coleman, Margaret.....	Detroit	Dysarz, T. T.....	Detroit
Breon, Guy L.....	Detroit	Coleman, Wm. G.....	Detroit	Dziuba, John F.....	Detroit
Briegel, Walter A.....	Detroit	Coll, Howard R.....	Detroit	Eakins, F. J.....	Detroit
Brines, O. A.....	Detroit	Collins, A. N. (Emeritus).....	Detroit	Eaton, Crosby D.....	Detroit
Bromme, Wm.....	Detroit	Collins, E. F.....	Detroit	Eder, Joseph R.....	Detroit
Brooks, A. L.....	Detroit	Collings, M. R.....	Detroit	Edgar, R. G.....	Detroit
Brooks, Clark D.....	Detroit	Colvin, L. T.....	Detroit	Eisman, Clarence H.....	Detroit
Brosius, Wm. L.....	Detroit	Colyer, Raymond G.....	Detroit	Elvidge, R. J.....	Detroit
Broudo, Philip H.....	Detroit	Condit, Irving.....	Detroit	Ely, Lloyd L.....	Detroit
Brough, Glen A.....	Detroit	Connelly, B. L.....	Detroit	Emmert, H. C.....	Detroit
Brown, Harvey F.....	Detroit	Connelly, R. C.....	Detroit	Ensign, Dwight C.....	Detroit
Brown, Henry S.....	Detroit	Connolly, Frank O.....	Detroit	Ensing, Osborne.....	Detroit
Brown, Stanley H.....	Detroit	Connor, Guy L.....	Detroit	Erkftz, A. W.....	Detroit
Brownell, Paul G.....	Detroit	Connors, J. J.....	Detroit	Eschbach, Joseph W.....	Detroit
Bruehl, Richard A.....	Detroit	Cooksey, Warren B.....	Detroit	Estabrook, B. U.....	Detroit



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Ettinger, Clayton.....	Detroit	Haig, D. B.....	Detroit	Jaeger, Julius P.....	Detroit
Evans, Wm. A., Jr.....	Detroit	Hale, A. S.....	Detroit	Jaekel, C. N.....	Detroit
Falick, M. L.....	Detroit	Hall, A. C.....	Detroit	Jaffar, Donald J.....	Detroit
Fandrich, Theodore.....	Detroit	Hall, E. Walter.....	Detroit	Jaffe, Julius L.....	Detroit
Farbman, Aaron A.....	Detroit	Hall, Ralph E.....	Detroit	Jashman, Wm. E.....	Detroit
Farbman, Simon S.....	Detroit	Hall, Robert J.....	Detroit	Jamieson, Robert C.....	Detroit
Fauman, David H.....	Detroit	Haluska, J. A.....	Detroit	Jarre, Hans A.....	Detroit
Fay, George E.....	Detroit	H'Amada, Norman K.....	Detroit	Jarzynka, F. J.....	Detroit
Felcyn, W. George.....	Detroit	Hamilton, N. C.....	Detroit	Jasion, L. J.....	Detroit
Fellers, Ray L.....	Detroit	Hamilton, S.....	Detroit	Jend, Wm. J.....	Detroit
Feldstein, Martin Z.....	Detroit	Hamilton, W. F.....	Detroit	Jennings, Alpheus F.....	Detroit
Fenton, E. H.....	Detroit	Hamilton, William.....	Detroit	Jentgen, C. J.....	Detroit
Fenton, Russell F.....	Detroit	Hammer, C. A.....	Detroit	Jentgen, L. G.....	Detroit
Fenton, Stanley C.....	Detroit	Hammer, E. J.....	Detroit	Jocz, M. W.....	Detroit
Ferguson, Thomas W.....	Detroit	Hammond, A. E.....	Detroit	Jocz, T. R.....	Detroit
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Schmidt, Harry E.	Detroit	Stockwell, B. W.	Detroit	West, H. G.	Detroit
Schneck, R. J.	Detroit	Stockwell, G. W.	Detroit	Weyher, Russell F.	Detroit
Schneider, Curt P.	Detroit	Stokfisz, T.	Detroit	Whalen, Neil J.	Detroit
Schoenfield, Gilbert D.	Detroit	Stone, D. D.	Detroit	White, Milo R.	Detroit
Schooten, Sarah S.	Detroit	Stone, Elizabeth A.	Detroit	Whitehead, L. S.	Detroit
Schreiber, W. F.	Detroit	Straith, Claire L.	Detroit	Whiteley, R. K.	Detroit
Schroeder, Carlisle F.	Detroit	Stricker, Henry D.	Detroit	Whitney, Elmer L.	Detroit
Schulte, C. H.	Detroit	Strickland, C. C.	Detroit	Whitney, Rex E.	Detroit
Schultz, Ernest C.	Detroit	Strickroot, F. L.	Detroit	Whittaker, A. H.	Detroit
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Scott, Wm. J.	Detroit	Summers, Wm. S.	Detroit	Wiener, I.	Detroit
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Shafter, Royce R.	Detroit	Tear, M. J.	Detroit	Wilson, W. J., Jr.	Detroit
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Skolnick, Max H.	Detroit	Tuttle, Wm. M.	Detroit	Zindler, Geo. A.	Detroit
Skrzycki, Stephen S.	Detroit	Tyson, W. E. E.	Detroit	Zinn, Geo. H.	Detroit
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## ROSTER MICHIGAN STATE MEDICAL SOCIETY

## WAYNE COUNTY MEMBERS OUTSIDE DETROIT

Angel, John J.....	Wayne	Evans, Leland S.....	Redford	Maibauer, B. W.....	Wyandotte
Ashton, F. B.....	Highland Park	Fine, Edward.....	Eloise	Martmer, Edgar.....	Grosse Pointe
Bagley, Harry E.....	Dearborn	Foley, Hugh S.....	Dearborn	Matthews, Wallace R.....	Dearborn
Bagley, Raymond B.....	East Dearborn	Footo, James A.....	Lincoln Park	McCormick, Colin C.....	Dearborn
Barker, F. Marion.....	Grosse Pointe	Goerke, Elmer A.....	Romulus	McGraw, A. B.....	Grosse Pointe Farm
Baskerville, R. J.....	Wayne	Grace, Joseph M.....	Eloise	Merkel, Charles C.....	Grosse Pointe Village
Beck, Eva F.....	Eloise	Gruber, T. K.....	Eloise	Miller, M. P.....	Trenton
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Blumenthal, Franz L.....	Eloise	Hammond, James L.....	Inkster	Phillips, Fred W.....	River Rouge
Bogusz, L.....	Eloise	Hanson, Frederick N.....	Eloise	Pinchard, Karl G.....	Dearborn
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Broderon, Harvey S.....	River Rouge	Hileman, Lee.....	Ecorse	Renz, Russell H.....	South Bend, Ind.
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Burrows, Howard A.....	Dearborn	Holcumb, August A.....	Northville	Roberts, Arthur J.....	Ecorse
Butterworth, Herman K.....	Lincoln Park	Honor, Wm. H.....	Wyandotte	Rogers, James D.....	Wyandotte
Caraway, James E.....	Wayne	Hudson, J. Stewart.....	Grosse Pointe Village	Root, Chas. T.....	Eckerman
Cavell, Roscoe W.....	Eloise	Huff, Reginald G.....	Wayne	Schenden, A. J.....	Melvindale
Chittick, Wm. R. (Emeritus).....	San Diego, Calif.	Humphrey, R. C.....	Lapeer	Schlacht, George F.....	Romulus
Church, Aloysius S.....	Eloise	Jennings, Robert M.....	Eloise	Schmidt, Milton R.....	Trenton
Coan, Glenn L.....	Wyandotte	Kehoe, Henry J.....	East Detroit	Sclaidy, Joseph E.....	Northville
Cohen, H. Herbert.....	Eloise	Kemler, Walter I.....	Ecorse	Shebasta, Bessy H.....	Eloise
Coolidge, Maria Belle.....	Grosse Pointe Park	Kern, W. H.....	Garden City	Snow, L. W.....	Northville
Craig, Henry R.....	Eloise	Kernkamp, Ralph.....	Eloise	Sparling, Harold I.....	Northville
Dubin, Joseph J.....	Dearborn	Klein, Louis.....	Nutley, N. J.	Squires, W. H.....	Eloise
Ely, Lloyd L.....	Grosse Pointe	Knox, Ross M.....	Ecorse	Stalker, Hugh.....	Grosse Pointe
Engel, Earl H.....	Wyandotte	Kwasiborski, S. A.....	Wyandotte	Stellhorn, M. C.....	Grosse Pointe
Erickson, Milton H.....	Eloise	Lemmon, Clarence W.....	River Rouge	Van Riper, Steven L.....	Eloise
		Lescoheir, Alex W.....	Grosse Pointe	Vincent, J. LeRoi.....	Wayne
		Lewis, J. Hugh.....	Wyandotte	Walker, Thaddeus.....	Grosse Pointe
		Linton, James R.....	Eloise	Wreggit, W. R.....	Highland Park
		MacKenzie, John W.....	Grosse Pointe		

## Wexford County

Albi, R. W.	Lake City	Holm, Augustus	Leroy	Mills, Robert E.	Boon
Brooks, G. W.	Tustin	Holm, Benton A.	Cadillac	Moore, G. P.	Cadillac
Carrow, J. F.	Marion	Hovertter, J. W.	Evart	Moore, S. C.	Cadillac
Doudna, H. E.	Albany, N. Y.	Laughbaum, T. R.	Lake City	Murphy, Michael R.	Cadillac
Gruber, John F.	Cadillac	McCall, J. H.	Lake City	Purdy, Calvin S.	Buckley
Hager, Ralph	Manton	McManus, Edwin	Mesick	Showalter, Laurence E.	Cadillac
Hendricks, H. V.	Kalkaska	Masselink, H. J.	McBain	Smith, Wallace J.	Cadillac

# President's Page

## EVERY PHYSICIAN A HEALTH OFFICER

MICHIGAN Medicine and the four thousand members of the Michigan State Medical Society are "on the spot" in their contention that treatment clinics are unnecessary in preventive medical procedures. Clearly, it is up to the physicians of this state to *prove* that the day of treatment clinics is past. Doctors must show Government, whether it be Federal, State or local, that they are able to do preventive medical work, and to handle the problems of syphilis control, tuberculosis control, immunization, and all phases of prevention as part of their own practices.

Government is showing a tendency to accept the medical profession's claim. The experiment of "Every Physician A Health Officer" is being tried out, now—at this very moment.

If the medical profession shows proof that it can handle this new field of work, in the practitioner's own office, then the program on the physician-patient basis will be continued and be enlarged.

If the profession does not rise to the occasion, if it throws away this splendid opportunity for greater service to the public, then it can expect to see "bigger and better" clinics, and will have no one to blame but itself for its own lethargy.

Men of Medicine, become *healthmen* in the modern field of preventive medicine.

Respectfully submitted,



President, Michigan State Medical Society.



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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MAY, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### SULFANILAMIDE

PERHAPS no other drug or medicinal agent has been written about and talked about to the same degree since its introduction less than three years ago, as sulfanilamide. Much as been claimed for it. It has been used to combat almost all kinds of infection with varying degrees of success. Like the proverbial two-edged sword, it has been found potent for harm as well as good. It is not a drug, by any means, for general consumption.

Elsewhere in this number of THE JOURNAL of the Michigan State Medical Society is an interesting presentation of the use of sulfanilamide in infections of the genito-urinary organs. This paper is submitted for publication by and we assume has the endorsement of the North Central Branch

of the American Urological Association. Doctors Breakey and Harrold have made a study of over 200 patients with infections of the upper urinary tract. The group consisted of ambulatory patients, for the most part not under institutional control, who may be considered as representing the patient who presents himself to the private practitioner. The group, two hundred and fourteen, to be exact (see classification, page 425), was studied with a view to ascertaining not only the beneficial effects, but any deleterious results as well. The authors have carefully tabulated the evidences of reaction to the drug. Adverse reactions subsided with the withdrawal of the medication, leaving no permanent untoward effects. Ten per cent of patients receiving sulfanilamide medication were found not to tolerate the drug well, with varying symptoms.

The authors of the paper, while recognizing the untoward symptoms possible, feel that sulfanilamide is very valuable in combating infections of the genito-urinary tract, particularly gonorrhea.

The reader's attention is called to the rather extensive bibliography. We purpose printing during the year a number of papers sponsored and approved by the North Central Branch of the American Urological Association which is represented by the Detroit Branch.

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### AMERICAN MEDICAL ASSOCIATION SURVEY

PERHAPS the majority of physicians are under the impression that medical care, for those who require it, is being adequately provided. A minority of physicians, among them those who are holding salaried positions, appear to think otherwise, and have so expressed themselves. The object of the survey conducted by the American Medical Association is to ascertain the truth of the matter. Is medical care adequate in the United States?

The agitation for change in the *modus* of medical practice has come for the most part from socially minded writers who have used up much space in lay magazines during the past few years. Little or no demand for change appears to have come from the people at large. Many, when questioned in regard to alleged state or socialized medicine, do not know what the questioner means.

Surveys are apt to be tainted by bias or

self interest. The social worker who has come into being of recent years is interested in making a place for himself in the scheme of things. It must not be denied, however, on the other hand that the doctor is also an interested person. We believe, however, that the doctor's long contact and association with not only the indigent sick, but with sick persons who are not indigent, places him in a better position to evaluate the needs of people than anyone more remote. The further fact that the doctor has been accustomed to render service gratis where needed should remove from him the reproach of being motivated by self interest. The traditions of his profession have acted as a sort of *noblesse oblige*.

The survey, the fact-finding part of it, is being left to the county medical society. This is about the only thing that can be done inasmuch as conditions vary with varying localities throughout the United States. Those chosen by county societies to aid in gathering facts will no doubt take the matter seriously, give it plenty of time, and approach the whole subject in a spirit of detachment, so that reliable data may be obtained. Various groups in the community are to be approached and given an opportunity to answer questions in their own language. The correlation of replies and the drawing of conclusions from factual data will be the function of the American Medical Association. The effect of this survey should be to let us know whether we are wrong or right in our impression in regard to the adequacy of medical care; for impressions they are, because no man can get beyond his immediate environment whether he is a general practitioner in the ranks, or a professor of medicine.

### EDUCATION BY FORCE

THE *Pennsylvania Medical Journal* calls attention to the difficulties of doting mothers in getting their children to practice music lessons on the violin or piano. "A considerable number of physicians," comments the *Pennsylvania Medical Journal* editorially, "are asked by fond and doting mothers what suggestions they have to make the children practice music lessons on the violin or piano. Many children are not adapted for music, more especially where systematic practicing is concerned. Some parents stand over the child with a strap at each time of practice

and beat the child into submission. By the time the youngster is brought under control at each seance, both the parent and the child are wrecks, mentally and physically. This is one of those household problems that really give much concern to parents, many of whom will do anything to force their offspring to practice music lessons as part of their culture."

The *Pennsylvania Medical Journal* goes on to bolster its position by quoting remarks of a professional musician as follows:

"He'd be a real musician if he would only practice. He's made splendid progress considering his lack of practice.' Those words almost say themselves so often have the music teachers said them. 'Lack of interest' would mean the same thing and come nearer explaining the children's hatred of the practice hour.

"We all understand that few of the children learning how to play musical instruments are going to be musicians in the professional meaning of the term, but many of them could learn to play well enough to give pleasure to other people and provide spiritual repose and enjoyment for themselves.

"Playing an instrument is a way of freeing the spirit of the pressure of life. Everybody needs some such outlet, but children do not know what you are talking about when you tell them that.

"To those parents who make great sacrifices to buy pianos and violins and pay for lessons for children who cry and storm and run away at the mention of practice time, my word is, 'Don't. It isn't worth it.' To those whose children show plainly that they can play, but hate the discipline which learning demands, my word is, 'Go ahead.'"

We quite agree with the above musician; by all means, music, if a child takes to it readily. This will also apply to education in other fields. Unless a boy or girl likes school and really takes great satisfaction and enjoyment from it, it is almost time wasted to try to force an "education," for it is attempting the impossible. You may lead a boy to college, but you can't make him think.

### CORPORATION PRACTICE OF MEDICINE

THE Medical Society of the District of Columbia has registered an objection to the practice of medicine by the Home Owner's Loan Corporation at Washington. The "Group Hospital Association" has been subsidized by a government gift of \$40,000 for the medical care of 6,000 HOLC employees who are being served by six salaried physicians, contrary to law, preventing the practice of medicine by a corporation. In retaliation to objections from the District of Columbia Medical Society and the American Medical Association, Congressman Scott of Cali-



foria introduced a resolution into Congress on March 28, calling for an investigation into the acts of the American Medical Association, and state and county medical societies, as well as the Medical Society of the District of Columbia.

Further explanation of the situation is well voiced in an address before Congress by Congressman Paul W. Shafer of the third district of Michigan. Congressman Shafer's address is the clearest and most logical example of reasoning that we have read in a long time and it is hoped that every member of the Michigan State Medical Society will peruse this splendid exposition of the subject. It is hardly necessary to go into detail since we publish this address in this number of *THE JOURNAL* of the Michigan State Medical Society. Congressman Scott's resolution (H. Res. 452), if passed, will affect every practicing physician in the United States. There is no particular objection to investigations. They, however, should not be one-sided. Those who bring charges against organized medicine should also be subject to just as searching an investigation. A bill for investigation of anything, if not based upon fairness to all concerned, is no investigation at all.

So far as we know, there is no law permitting the practice of medicine by lay corporations hiring doctors to do professional work. There have been numerous attempts at such exploitation. However, they have never been sanctioned by law. A vigorous protest is being presented against the attempt being made on the part of the governmental agencies. If governmental agencies are permitted to practice medicine or dentistry, there seems no reason why any other lay group should not enter upon medical practice by hiring doctors to give the actual medical and surgical care which would in time call for advertising campaigns to stimulate business, for such it would become

### THE BOTTLE HABIT

"Once again the annual report of the prescription-pricing department of the Lancashire Insurance Committee reveals the inordinate and growing belief of the panel patients of the county in the virtues of the medicine bottle. Twenty years ago, when the number of patients accounted for in the doctors' drug statistical data for the county was about half a million, the number of prescriptions issued was just under a million and a half. Last year some three-quarters of a million patients accounted for about four million prescriptions. The increase in the cost of drugs is even more startling. In 1917 it was

£39,679 (\$198,395), in 1937 it had risen to £137,969 (\$689,845). And if further proof be needed of Lancashire's insistence on having its medicine it is to be found in a column which shows that the average number of prescriptions per person insured has risen in twenty years from 2.91 to 5.24. It is a rate of increase much in excess of that for the country as a whole, and it is hard to account for."—*Manchester Guardian*.

Further comment on panel practice of medicine would be superfluous.

Customer—"You made a mistake in that prescription I gave my mother-in-law. Instead of quinine you used strychnine."

Druggist—"You don't say! Then you owe me 20 cents more."

Mrs. A.—"Jimmie has been in the third grade for two years. I wonder how he will ever get ahead?"

Mr. A.—"Don't know. If he wasn't born with one, he never will."

Boarder—We've had chicken four times this week.  
Visitor—Four chickens! This must be a great boarding place!

Boarder—Oh, it was the same chicken.

### SOWING AND REAPING

Oh, it may be no sae funny, this scheme o' sowin' debt

If it disna reap a harvest that will see th' bills a' met,

We'll no be hearin' eulogies, bit raither we'll be flayed

When inither generation pays th' debts that we hae made.

Oh! it's nae sae verra funny if yer doin' work that's free,

An' oor government officials drawin' doon their usual fee,

An' pilin' oop expenses, sae that nae man can earn Enough tae pay his taxes or his grocery concern.

We may better keep th' money for oor taxes tae oorsels

An' let th' politicians use th' land that they may seize

Tae cover their expenses, wi' not a penny more Unless they mak a profit an' show a balance o'er.

Dae ye think oor politicians wull hae' th' nerve tae face

Their sons' and daughters' bairns that may be aboot th' place,

An' tae luvie them an' tae kiss them an' tickle o' their feet,

When th' biggest thing they've gi'en them, a debt they canna meet?

Noo ah dinna do complainin' mair than any ither maun,

Bit ah'd like tae hae explained tae me th' basis o' th' plan

That pits mair money in yer pooch—oh, how ma hert does yearn

Tae ken that plan that saves ye money by spendin' mair'n ye earn.

WEELUM

JOUR. M.S.M.S.

# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## THE A.M.A. SURVEY— YOUR OPPORTUNITY!

### Objectives:

1. *Diagnosis.* To determine the prevailing medical and preventive medical needs in each county.
2. *Treatment.* To develop preferable procedure to supply the needs where medical and preventive services are insufficient or unavailable.

I. The first phase of the study is fact-finding.

II. The second phase of the study involves the analysis of factual data and the preparation of a report of appropriate methods to meet the needs if at present they are improperly supplied.

III. To insure the highest degree of accuracy and completeness, a sufficient amount of time must be taken on this study. Haste is inconsistent with good scientific and social investigations.

It must not be inferred that it is necessary for all county medical societies to recommend some new procedures. If from the study it appears that medical needs in the county are now being met satisfactorily, it is of as much importance to make a report to that effect as, in other instances, to recommend measures to correct insufficient or unavailable services.

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"Every physician a health officer"

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## GOVERNOR MURPHY'S STATEMENT RE: SURVEY

THE State Welfare Department, the Michigan Department of Health and the Michigan State Medical Society have had frequent conferences relative to the medical needs of welfare, old age and W.P.A. clients.

Quite obviously there is need for additional medical care for many of these people. However, the extent of such needs, the inequalities in distribution of care, and the legal obstacles to providing additional and improved medical care are all subjects for intensive study in order that the problem may be properly solved.

The Michigan State Medical Society already is undertaking such a study. The State of Michigan is desirous of offering its every assistance to the medical group in pursuing this survey. Therefore, I wish to announce the appointment of the following persons as members of a committee to coöperate with a committee ap-

pointed by the State Medical Society and all official and non-official state agencies and departments concerned with this important problem.

Dr. Don W. Gudakunst, State Commissioner of Health.  
Mr. James Bryant, Director, State Welfare Department.  
Mr. George F. Granger, State FERA.  
Nelle Williams, Old Age Assistance Bureau, State Welfare Department.  
Dr. Ralph Pino, Detroit.  
Dr. Paul Kniskern, Medical Director, Kent County, FERA.  
Dr. R. G. Tuck, Medical Director, Oakland County FERA.  
Mr. A. N. Hennigar, Detroit Board of Education.  
Mr. John Reid, Secretary, Michigan Federation of Labor.  
Mr. R. A. Broadbent, Lansing, Michigan Pharmaceutical Assn.  
U. G. Rickert, D.D.S., President, Michigan State Dental Society.  
Mr. Charles Wennegar, Chrysler Corporation, Detroit.  
Mr. Harry J. Kelley, American Seating Company, Grand Rapids.  
Mr. Ray Baartz, Detroit Council of Social Agencies.

It is hoped that this committee can not only assist the Medical Society in discover-



ing the facts, but that ways and means can be outlined for the complete utilization of the professional and technical skills now existing in our state for the benefit of our people.

April 6, 1938.

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"All medical progress begins with **you**."

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## M.S.M.S. OBJECTIVES AND ACTIVITIES

### II. ECONOMIC:

The Michigan State Medical Society and its component county societies bring you these valuable benefits of membership:

1. Participation in the varied activities of the county and state medical societies—all designed to preserve the physician-patient relationship.
2. Protection against state and national legislation inimical to public interests and advancement of medical science; constructive efforts to initiate beneficial health measures; important contacts to effect the proper administration of existing laws.
3. Defense of your profession and your source of livelihood from encroachments from without.
4. The bulwark of an organized profession in medical-legal matters.
5. Information and action on fraudulent schemes, inferior products, and pseudo-medical practitioners through close coöperation with the State Department of Health, the State Board of Registration in Medicine, and other departments at your State Capitol.
6. Privilege of becoming an active member of the Michigan Health League.
7. Assistance in obtaining appointments as examiner for insurance companies, state departments, and other organizations.
8. Personal service of your Executive Office in Lansing in matters associated with your practice of medicine.

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"Every physician a health officer"

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## UNHEALTHY POLITICALIZATION OF MEDICINE

SENATOR Wagner of New York recently introduced in the United States Senate a resolution providing for the appointment

of a select committee of the Senate to conduct an investigation of medical service in the United States; this appears to be a preliminary to a socialized medicine bill which Mr. Wagner has threatened to introduce.

Is Senator Wagner trying to intimidate individual members or groups of physicians to stop fighting against a corporation illegally practicing medicine? Is Senator Wagner et al. attempting to develop a defeatist attitude in the medical profession in order "to divide, and rule"?

Will the Wagner bill, if enacted into law, divide the medical profession as has his N.L.R. Act (designed to *help* labor, not divide it!)? The N.L.R.B. has been dissolving A. F. of L. contracts and ordering new elections in ways that keep the A. F. of L. constantly irritated and more and more averse to an agreement with the C.I.O.

If Senator Wagner's political panaceas cannot work in the economic field, what chance for success (benefit to the people) will they have in the more highly personal field of medicine?

Political meddling in medicine is always disillusioning, if not disastrous, to the people. A physician's responsibility is, first, to warn his patients against the dangers of political medicine; second, to fight in the front-line trenches against any scheme which will deteriorate medical care in this country.

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"All medical progress begins with **you**."

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## EXECUTIVE COMMITTEE OF THE COUNCIL

March 13, 1938

## HIGHLIGHTS:

1. Governor Murphy offers help to the Michigan State Medical Society in the work of the A.M.A. Survey.
2. Right of employes of state penal institutions to choose their own physicians is reaffirmed and demanded.
3. Request is made for amplification of Attorney General's opinion re interpretation of x-ray plates.
4. The Filter System is made official by the Michigan Crippled Children Commission.
5. The State Society's representatives to the Michigan Health League are appointed.
6. The Gudakunst-Salter series of articles on "Health Factors of Middle Age" are approved for publication in newspapers of the state.
7. Fifty eminent speakers, on annual meeting program in Detroit, September 20, 21, 22, 1938, are approved.

1. *Roll Call.*—The meeting was called to order in the Statler Hotel, Detroit, by Dr. P. R. Urmston at 3:15 P. M. Those present: Drs. Urmston, A. S. Brunk, H. R. Carstens, I. W. Greene, P. A. Riley. Also present: Drs. Henry Cook, H. A. Luce, L. Fernald Foster, J. H. Dempster, M. H. Hoffmann, R. H. Holmes, L. G. Christian, L. O. Geib, R. H. Pino, G. C. Penberthy, Health Commissioner Don W. Gudakunst, Drs. C. K. Hasley and H. B. Fenech, and Executive Secretary Wm. J. Burns. Absent: Dr. V. M. Moore.

2. *Minutes.*—The minutes of the meeting of February 9 were read and approved.

3. *Financial Report.*—The financial report for February, 1938, was presented, accepted and ordered placed on file. Bills Payable were presented, and ordered paid on motion of Drs. Carstens-Greene. Carried unanimously.

4. *Report of Contact Committee to Governmental Agencies.*—Drs. Cook and Urmston reported on conferences with Crippled Children Commission on February 15 and March 2 in Lansing. A full discussion ensued relative to the various points, and in particular the filter system.

Recent action of the Commission: An executive order making the filter system official was being considered by the commission.

The Executive Secretary reported on the radiological schedule as presented to the Crippled Children Commission by the Michigan Association of Roentgenologists.

5. *A.M.A. Survey.*—This matter was discussed, and Health Commissioner Gudakunst stated that the Governor would offer help in the study, to survey wards of the state, and reported that the study committee would be composed of representatives of the MSMS, medical directors of the E.R.A., social agencies, Welfare Department, State Health Department, Education, large and small Industry and Labor. Dr. Foster explained the details of the A.M.A. survey, to be medically conducted. Motion of Drs. Greene-Brunk that the Michigan State Medical Society make the official survey as suggested by the American Medical Association. Carried unanimously.

After further discussion, motion was made by Drs. Carstens-Greene that the MSMS Public Relations Committee be instructed to stimulate all necessary study, interpretation and activity on the part of the county medical society. Carried unanimously.

Motion of Drs. Brunk-Carstens that State Health Commissioner Gudakunst be advised that

we wish to contact the Governor re the survey of wards of the state; that the Contact Committee to Governmental Agencies has authority to so contact the Governor and the State Health Commissioner, and to report back to the Executive Committee of The Council. Carried unanimously.

6. *Attorney General's Opinion re Interpretation of X-Ray Plates.*—This matter was presented by Dr. C. K. Hasley for the Michigan Association of Roentgenologists. The matter was thoroughly discussed, and Drs. Dempster and Hasley were requested to draft a letter for presentation to Attorney General Starr.

The letter, as drafted, was presented to the Executive Committee of The Council and approved, with instructions that it be sent to Attorney General Starr, on motion of Drs. Riley-Brunk. Carried unanimously.

7. *Report of Legislative Committee.*—Dr. L. G. Christian, Chairman, reported on the recent meeting of the Legislative Committee. Motion of Drs. Carstens-Riley that the Legislative report be accepted. Carried unanimously.

8. *Investigations of Violations of Medical Practice Acts.*—A report on this matter was presented, and accepted.

9. *Syphilis Control Bill in Congress.*—President Cook reported on this matter, and on his letter to Senator Vandenberg urging that a conservative but ample appropriation should be considered; he read Senator Vandenberg's reply, suggesting that a 3-year appropriation, to give the experiment time to prove itself, was sufficient.

10. *Michigan Society for Mental Hygiene.*—President Cook spoke of the meeting of April 8, which was thoroughly discussed. No action taken.

11. *Civil Service Commission.*—The matter of the Civil Service Commission's proposed examination of prospective state employes, by which physicians in penal institutions might be required, according to the instruction sheet, to furnish medical care to prison employes, was discussed. Motion of Drs. Carstens-Brunk that a letter be written to the Civil Service Commission reaffirming the position of the MSMS that physicians employed by penal institutions shall not furnish medical service to employes, thereby depriving these citizens of the right of choosing their own physician. Carried unanimously.

12. *Parole Commission.*—Dr. Riley, as Chairman of the Contact Committee with Parole Commission, reported that his committee had transmitted its decisions re consultation service and fees there-



for to the Parole Commission; the Parole Commission had discussed this matter in Jackson on January 25 and had referred the matter to the Civil Service Commission. Motion of Drs. Brunk-Carstens that the report be accepted. Carried unanimously.

13. *Committee on Scientific Work.*—Dr. Foster reported on the February 20 meeting of this committee. He stated that the 1938 annual meeting would begin as usual with a House of Delegates' Breakfast, and continue with many activities and fifty speakers until Thursday afternoon at 5:00 p. m., September 22, 1938. The suggestion that the Ear, Nose and Throat section have a section meeting all day Wednesday was not looked upon favorably by the Executive Committee of the Council.

Motion of Drs. Carstens-Brunk that the report of the Committee on Scientific Work be accepted, including its recommendation that only one-half day (Wednesday, September 21) be devoted to section meetings. Carried unanimously.

14. *Michigan Health League.*—Dr. Christian reported on the formation of the League and the approval of its Constitution and By-Laws, which was referred back to the Executive Committee of the Council of the M.S.M.S. for its approval. Motion of Drs. Carstens-Brunk that a copy of the constitution of the League be sent to each member of the Executive Committee, with the request that he study same, write his comments to Chairman Urmston and Secretary Foster, who shall combine the various suggestions, with power to act. Carried unanimously. Motion of Drs. Carstens-Greene that the M.S.M.S. contribute its contribution of \$50.00 to the Michigan Health League, at this time. Carried unanimously.

Motion of Drs. Greene-Riley that the present nominations to the Health League (Drs. Christian, Gruber, Tuck) be approved by the Executive Committee of the Council. Carried unanimously.

Motion of Drs. Riley-Brunk that the three representatives of the Michigan State Medical Society to the Health League use their influence to see that the M.S.M.S. Legislative Committee Chairman be made a member of the Executive Committee of the League. Carried unanimously.

15. *Report of Medico-Legal Committee.*—The monthly report, as presented by Secretary Wm. J. Stapleton, Jr., was read, and accepted on motion of Drs. Brunk-Carstens. Carried unanimously.

Dr. Carstens spoke of the report of the Secretaries' Conference held at the A.M.A. in Chicago last

November re what other states are doing in medico-legal work. Motion of Drs. Carstens-Greene that this be referred to a committee for study and report. Carried unanimously.

Committee appointed: Drs. Greene, Holmes, Andrews.

16. *Title "Dr." Used by Chiropractors.*—A recent opinion of the Attorney General denying chiropractors the right to practice medicine or use the title "Doctor" was read.

17. *Report of Cancer Committee.*—Report of the meeting of March 12 was presented, received, and placed on file. It was suggested that the doctor's small leaflet re cancer might be published in the JOURNAL, to save expense.

18. *Northwest Conference.*—President Cook and Secretary Foster reported on the meeting of the Northwest Conference in Chicago on February 13. Dr. Foster suggested improvements in the form of organization of this association. Motion of Drs. Carstens-Brunk that the Secretary's suggestion meets with the approval of the Executive Committee of The Council. Carried unanimously.

19. *Postgraduate Courses.*—Secretary Foster reported on the individual postgraduate courses in obstetrics, which the State Department of Health is trying to arrange at the present time.

20. *From the Wayne County Medical Society.*—(a) Suggestion to discontinue o.p.d. fees under the Afflicted Child Act. This was discussed, and the Executive Committee instructed the Executive Secretary to ask for specific and detailed information from the Wayne County Medical Society, in order that it may proceed with any necessary investigation.

(b) That the state help to remove 3,000 state mental cases from Eloise Hospital to make room for Wayne County Medical cases now housed inadequately in Receiving Hospital, Detroit. This was discussed generally, and the Executive Committee deplored the present conditions. However, the Governor is gradually relieving the situation, as more room is being made at Ypsilanti.

21. *"Health Factors of Middle Age."*—The Executive Committee discussed the reprinting of this series of articles, written by Dr. D. W. Gudakunst and Lawrence C. Salter, for all the small newspapers of the state, under the sponsorship of the M.S.M.S., the State Department of Health, and the Joint Committee on Health Education. Motion of Drs. Brunk-Riley that this be approved. Carried unanimously.

22. *Adjournment.*—The meeting was adjourned at 11:25 p. m.

### SEE STARS—HEAR STARS—SEPTEMBER MEETING

A constellation of medical stars will make brilliant the 1938 annual meeting of the Michigan State Medical Society, in Detroit, September 20, 21, 22. Twenty-seven guest speakers from all parts of the country and abroad will be featured on the General Assemblies; a like number of Michigan teachers and lecturers will be presented on the section programs. Among the acceptances of out-of-state speakers, to date, are:

C. A. Aldrich, M.D., Winnetka, Ill.  
Joseph Baer, M.D., Chicago, Ill.  
O. B. Batson, M.D., Philadelphia, Pa.  
Henry A. Christian, M.D., Boston, Mass.  
Franklin G. Ebaugh, M.D., Denver, Colo.  
Haven Emerson, M.D., New York, N. Y.  
Morris Fishbein, M.D., Chicago, Ill.  
Howard Fox, M.D., New York, N. Y.  
John Gordon, M.D., Boston, Mass.  
Roy R. Grinker, M.D., Chicago, Ill.

Henry F. Helmholtz, M.D., Rochester, Minn.  
Harold O. Jones, M.D., Chicago, Ill.  
Frank H. Lahey, M.D., Boston, Mass.  
William D. McNally, M.D., Chicago, Ill.  
F. W. Rankin, M.D., Lexington, Ky.  
A. D. Ruedemann, M.D., Cleveland, Ohio  
Kellogg Speed, M.D., Chicago, Ill.  
Fred Taussig, M.D., St. Louis, Mo.  
A. F. Voshell, M.D., Baltimore, Md.



## CONGRESSMAN SHAFER (MICH.) FIGHTS SOCIALIZED MEDICINE

*[The following address was made by Congressman Paul W. Shafer of Battle Creek, Michigan, in the U. S. House of Representatives, Washington, D. C., on March 29, 1938]\**

A resolution has been introduced in the Congress—Monday, March 28—by the gentleman from California [Mr. Scott] calling for an investigation into the activities of the American Medical Association, State and county societies, and the District of Columbia Medical Society.

This resolution is the outgrowth of a controversy between the Group Health Association—originated to provide medical care for employees of the Home Owners' Loan Corporation—and the Medical Society of the District of Columbia.

In connection with this controversy, the gentleman from California has made several serious charges on the floor of this House which have been given wide publicity. These include charges of unethical practice by members of the District of Columbia Medical Society and the accusation that members of the society are conspiring to create a monopoly of the practice of medicine, on their own terms, in Washington hospitals. My interest in the controversy is explained by the fact that I am a member of the Subcommittee on Hospitals and Charities of the Committee of the District of Columbia, and inasmuch as these charges involve hospitals in the District of Columbia, I have felt it my duty to investigate the accusations. I have made a cursory investigation on my own initiative and I take the floor today to advise the membership of my findings.

I might observe at this point that the results of my personal inquiry show that if an investigation resolution is adopted, it should also provide for an investigation of the G. H. A.—Group Health Association—as well as the Medical Society. In fact, if the resolution presented by the gentleman from California is adopted without including the G. H. A. in the investigation, I shall introduce a similar resolution to bring the G. H. A. under the scope of the investigation.

From my findings I have no doubt but that an investigation into the activities of the Medical Society of the District of Columbia would vindicate that organization and its members of unethical conduct. In fact, I have learned that the members of the District of Columbia Medical Society are as anxious that this investigation be held as its proponents, in order that the loose accusations, and the implanting in the public mind of doubts as to the high morals and ethics of the members of the society, may be disproved.

In connection with his resolution the gentleman from California made the statement that—

The District Medical Society is doing everything it can to break up the G. H. A. movement and is receiving assistance from the American Medical Association.

The fact is, the Medical Society has done nothing of the sort. When the G. H. A. was originally organized to provide adequate medical care for employees of the H. O. L. C. and other Government employees, the District Medical Society offered its co-operation to help provide this medical care. The offer was made in good faith, with but one proviso, that being that the program to be worked out could not violate the legal, ethical, and professional standards of the society.

\*Acknowledgment is made to the *Congressional Record* for permission to reprint this address, which is exempt from the copyright provisions of the M.S.M.S. JOURNAL.

## "Medical Ethics" Defined

By way of explanation I might state that these standards of the Medical Society were not conjured overnight by any group of laymen. They are self-imposed limitations upon the medical profession for the protection of the public, built up as a result of practical and costly experiences over three centuries of medical practice.

The G. H. A., however, insisted that the society provide medical service for this organization on G. H. A.'s own terms, which the medical society found impossible. If the G. H. A. felt those standards were correct, and the medical society was wrong, it certainly had the right to insist upon them; but, by the same token, the medical society hardly could be expected to abandon its own principles in order to comply with the ultimatum of the G. H. A.

The points in conflict were:

First. That the program must be legal.

Second. That it must be economically sound, so that the quality of service rendered could not be sacrificed in order to render the service at a reduced rate.

As to the economical soundness of this program these facts should be noted:

### Quality Service Suffers

In any program of this kind the primary purpose is to render medical service at a reduced cost. The objective is to give the individual the same amount of medical care that is received by persons of comfortable circumstances but at a reduced rate. In order to do that a sacrifice has to be made in one of two places. Either the physician who handles this type of work must receive less income or his income must be made up by a larger number of patients, which means less time and less attention to each individual.

The fallacy of the Group Health Association program is that all of this sacrifice for 6,000 members is concentrated on six physicians. In order to pay the salaries of the six doctors it has been necessary to admit more and more members to the association and to cut down heavily on the amount of time and attention available for each patient.

Had this program provided for free choice of physician, the sacrifice would have been spread over hundreds of physicians in the city of Washington. (A total of 1,979 physicians.) Each one could have afforded to handle his share of this practice at a reduced rate and still give the usual time and attention to the patient.

For six physicians to purport to give complete and unlimited medical attention to 6,000 individuals—a thousand persons for every doctor—is plainly impossible. Actual results show that. Just as the past experience of the medical society indicated, the physicians of Group Health Association have been more and more overburdened with work. There are many cases having to wait for long periods before receiving attention.

### Illegal Practice by a Corporation

As to the legal phase:

A government gift of \$40,000, necessary in order for G. H. A. to begin operations at all, was held by the Comptroller General and the House Appropriations Committee to have been illegal and improper.

The Healing Arts Act of the District of Columbia makes it unlawful for any corporation to practice medicine. There are many reasons for this, but, regardless of the reasons, the law is on the books. The medical society received a formal legal opinion from its counsel that Group Health Association is a corporation engaged in the practice of medicine in violation of the healing-arts law.



The United States district attorney here also has ruled the same way.

The corporation counsel has ruled that Group Health Association is operating in violation of the insurance laws of the District of Columbia. Group Health Association has requested a declaratory judgment from the local courts on those two points in the hope of overruling these adverse decisions, but so far such judgments have not been handed down.

One of the requirements for membership in the medical society of the District of Columbia is that the physician must be engaged in legal practice of medicine. The same eligibility requirement is maintained by all hospitals in the District of Columbia. Plainly, such a requirement is necessary. The District Medical Society has no more right to permit a physician of Group Health Association to be a member of the society in good standing under these rulings than it would have to permit some physician who is guilty of criminal practice to retain his membership. The hospitals are in an identical position.

### Group Health Association Physicians Engaged in Illegal Practice

In short, the physicians of Group Health Association are engaged in illegal practice, and the hospitals or the Medical Society would be compounding this violation of law by having professional relationships with these physicians.

Among the many reasons why corporation practice of medicine is held to be inimical to the public interest is the fact that any such corporation set up for commercial marketing of medical service tends to wipe out the fundamental essential of good medical care—the personal attention and interest by the physician to the individual patient.

If medicine were a completed science in which symptoms could be dialed into a computing machine—a crank turned—and a box of the proper pills discharged from a slot, the considerations might be different. This, however, is not the case. Medicine is only an infant science. The eccentricities, peculiarities, and individual factors in human beings make every diagnosis and treatment dependent very heavily on personal deduction, allowances for this and that, and careful reasoning by the physician.

### Disastrous Results to Public

Another objection to the corporation practice of medicine is that where medical service becomes a medium of profit by a corporation with lay stockholders interested primarily in whether the corporation pays dividends or not, the results to the public are disastrous.

In this connection, fancy the outcome if several large corporations were set up in the District of Columbia to sell medical care to the public. In commercial competition with each other, their objective would be to compete for membership and to get as many paying members as possible to increase the total of business. It is not inconceivable that door-to-door solicitors might be calling upon housewives like Fuller Brush salesmen, to sell memberships. With salesmanship their only interest, the method of sale, of course, would be to build up fear in the individual's mind and thereby show the value of this service. It is a physical fact that such a practice as this probably would have dire effects on the general public welfare. Fear, imagination, and similar emotions are closely tied to the physical health of any individual.

The present controversy was begun by the Group Health Association when one of its members was refused admittance to a district hospital (Garfield) when it was ascertained by hospital authorities that

emergency surgery was not needed. The patient later underwent an operation at another hospital (Columbia).

Speaking on the floor of the House, the gentleman from California [Mr. Scott] made the following statement:

A certain woman is a secretary in one of the Government departments. She belongs to the Group Health Association. She went to the hospital, being sent there after examination by a physician employed by the Group Health Association. He sent her to the hospital with a diagnosis of appendicitis. The doctor who sent her there was Dr. Selders of the Group Health Association clinic. She was admitted to the hospital and made ready for the operation. Doctors and attendant nurses had dressed themselves in preparation for the operation and morphine was administered to her by an employee of the hospital, and then the question was raised by the resident physician whether or not Dr. Selders was to be permitted to operate on this young woman. The resident physician said, "No; he is employed by the Group Health Association and cannot operate in this hospital."

The young woman refused to accept any other doctor and said, "Dr. Selders has taken care of me. He knows my condition and I want him to operate on me because I have confidence in him."

They would not allow this, and thereupon the superintendent of the hospital refused to allow the operation to proceed. The resident physician, without consultation with other medical authorities, declared the case was not an emergency case, going on record to that effect in writing, and the girl was taken out of the hospital. This despite the fact that G. H. A. patients are let into hospitals only in emergency cases, and even then not all the hospitals will take emergency cases.

Forty-eight hours later the young woman was operated upon by another physician in another hospital, and it was found at that time her appendix had ruptured. The resident physician in the first hospital would not let her be operated upon because she wanted her own doctor, said it was not an emergency case, and sent her out of the hospital after an employee of the hospital itself had injected morphine into her in preparation for the operation. What might have happened did not happen, because she lived. The operation was successful. (Pp. 5135, 5136, *Congressional Record*.)

My personal investigation shows that the circumstances stated in connection with this case are not based on fact. The patient never entered the operating room at the hospital. Dr. Selders knew in advance that the only grounds under which he might be accorded surgical privileges at this hospital—Garfield—was for emergency surgery. He took the patient to the hospital and claimed she was suffering from acute appendicitis and that an emergency operation was necessary. Documentary evidence shows that the patient was examined by the hospital physicians who found she did not have an acute appendix, and that an emergency operation was not necessary. They refused to permit the operation but offered to call any surgeon the patient might request. The patient did insist upon Dr. Selder's performing the operation and finally left the hospital. Two days later she was operated upon at another hospital—Columbia—by a recognized physician of that hospital's staff.

Documentary evidence from the surgeon who performed the operation and from the pathologist who examined the appendix shows that the appendix had not ruptured and that the patient did not have acute appendicitis. I have here an attested copy of a letter written by Truman Abbe, M.D., the surgeon who performed the operation, addressed to Dr. Thomas E. Neill, President of the Medical Society of the District of Columbia. The letter reads:

DEAR DR. NEILL: In response to your request for information about the condition of the appendix from the patient of the G. H. A. upon whom I operated on March 1, 1938, I have asked her permission to report to you (for public information, if necessary) that I found no acute condition in the abdomen, and that the pathologist's report on the appendix was "chronic appendicitis."

Sincerely yours,

TRUMAN ABBE.

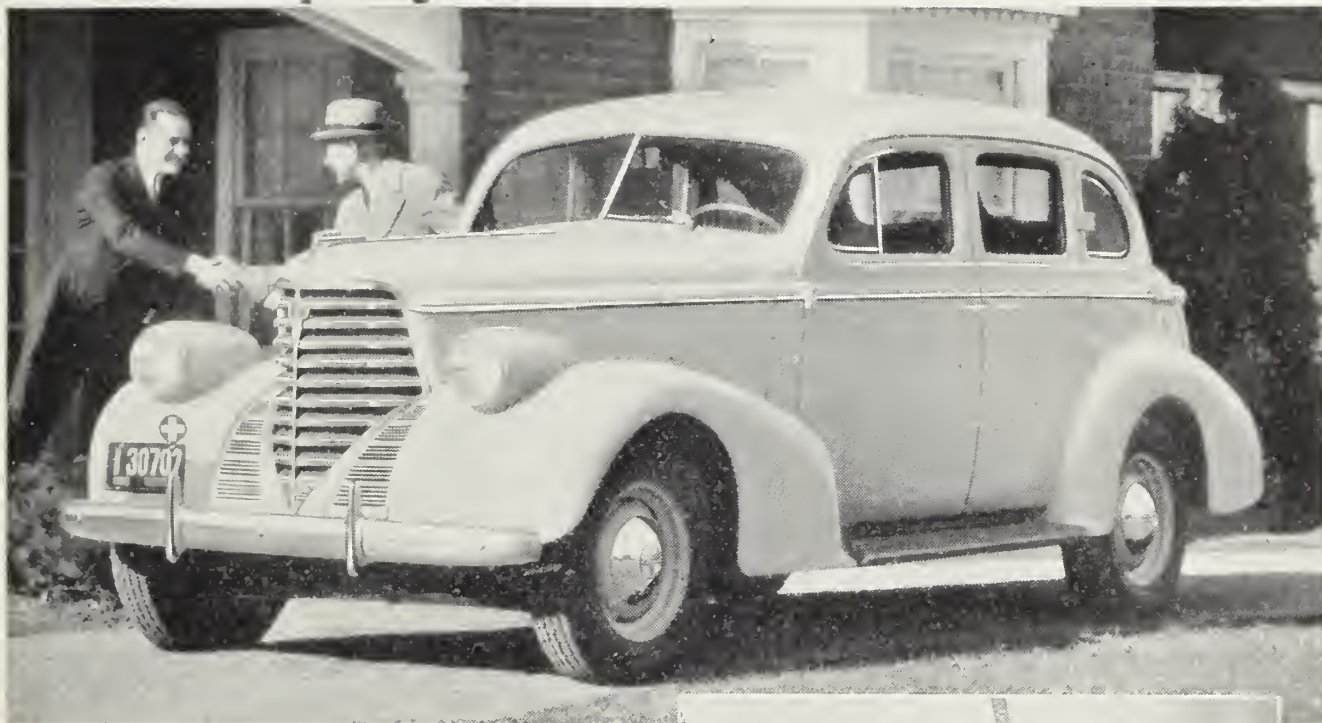
In view of these facts, it would appear that Dr. Selders, the G.H.A. physician was guilty of one of two things in this case. Either he was woefully mis-

(Continued on Page 456)



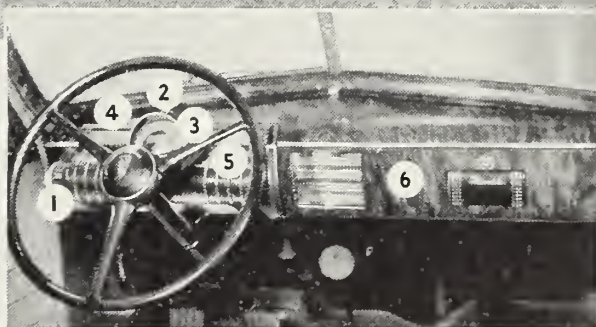


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(Continued from Page 454)

taken in his diagnosis of the woman's illness, or he deliberately attempted to force his way into the hospital under false pretenses.

If it was an honest mistake, it seems to indicate that the hospitals of the city of Washington are justified in refusing him permission to operate on the grounds of professional capability, as well as on the grounds that he is engaged in illegal practice. If it was a case of false pretenses, it is a sad reflection on the ethics and integrity of Dr. Selders and the G.H.A., that any patient should be deliberately subjected to the mental stress here involved and used as a tool of trickery.

In accusations of this kind it is better to have the facts established immediately than to allow the medical profession to be exposed to such loose charges. I have no doubt that an investigation would vindicate members of the District of Columbia Medical Society completely and for that reason I would support the resolution of the gentleman from California if it were not national in scope. I regard this controversy as a purely local situation, as I stated before, and I see no reason for extending this proposed inquiry beyond the borders of the District. I am at all times ready to favor an investigation into charges against the medical profession or any of its reputable members because I believe that, except perhaps in isolated cases, such charges are idle gossip which would be disproved by an orderly investigation, and because I believe the medical profession is too important, its ideals are too fine, its service to humanity is too great, and its necessity to human welfare is too vital to allow it to be rendered suspect. I believe the members of the District of Columbia Medical Society, whose conduct has been brought into question, should be given a full opportunity to establish, in an orderly and convincing way, the falsity of these charges.

#### COUNCIL AND COMMITTEE MEETINGS

1. Thursday, March 24, 1938—Mental Hygiene Committee—Eloise Hospital, Eloise—7:30 p. m.
2. Saturday, April 2, 1938—Medico-Legal Committee—David Whitney Building, Detroit—12:00 noon.
3. Wednesday, April 13, 1938—Liaison Committee with Hospital Association—Wayne County Medical Society Building, Detroit—4:00 p. m.
4. Thursday, April 14, 1938—Executive Committee of The Council—State Health Department Laboratories, Lansing—2:00 p. m.
5. Wednesday, April 20, 1938—Committee on Postgraduate Medical Education—Wayne County Medical Society Building, Detroit—2:00 p. m.
6. Thursday, May 5, 1938—Advisory Committee to Woman's Auxiliary—Hotel Olds, Lansing—6:00 p. m.
7. Wednesday, May 18, 1938—Executive Committee of The Council, Liaison Committee with Hospital Association, and Trustees of Mich. Hospital Association—Eloise Hospital, Eloise—2:00 p. m.

## What County Medical Societies Are Doing

### JACKSON'S SYPHILIS CONTROL PROGRAM

By EDWARD D. CROWLEY, M.D., Jackson

THE Jackson Academy of Medicine and Dentistry has a contract with the Board of Supervisors of Jackson County to supply medical care to indigent patients in the venereal disease group for a stipulated sum. Patients can go to the physician of their own choice, and adequate treatment is guaranteed.

Treatment is followed according to the specifications laid down by the Michigan Department of Health.

The routine that is carried out in Jackson County is as follows: When a positive Kahn or G. C. smear is obtained on an indigent case, this case is referred to our Poor Commissioner so that he will guarantee that the case is really indigent. After this approval is obtained, the patient returns the card, signed by the Poor Commissioner, to the doctor, who in turn reports the case to the secretary of the Academy. Treatment is then started, and each treatment is recorded by the physician on a special chart. After two months these treatment charts are returned to the secretary of the Academy; in this manner careful check is made that the treatment is being adequately carried out. This chart is signed by the patient, as well as by the M.D. If a case is delinquent two treatments, another card is sent to the secretary, who in turn reports to the Board of Health, and this case is immediately followed up and requested to return to his physician for treatment. Kahns are required four times a year, and gonorrhea smears must conform to the State regulations before a case of gonorrhea is discharged.

We find that this type of follow-up of cases is very effective in having these patients continue their treatments. It is working very satisfactorily in Jackson. We have splendid coöperation from the Board of Health, and this is what makes the plan effective.

The contract that we have with the Supervisors pays the physician approximately \$50.00 a year for the treatment of syphilis, and \$30.00 for the treatment of gonorrhea. The fee that is paid to the physician for these cases is, on a sliding scale, according to treatment given. All medication is furnished free by the State.

This program maintains the physician-patient contact, where before these patients were treated in the clinics.

Any questions in regard to a more detailed operation of our plan will be gladly answered by corresponding with the secretary.



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Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### A MESSAGE FROM THE PRESIDENT

As each Auxiliary is planning to close the program for the year, the days are full of duties for all lest we be not able to enjoy the recess so near at hand.

Mrs. Page and I have enjoyed the courtesies extended to us as we have accepted invitations to attend meetings. Of course Bay County came first, then Ingham County, January 24, where we heard Dr. Clara Davis, speak of her conclusive ideas regarding food for children and the psychological influence of the day in character building. It was a real pleasure to chat with Dr. Davis, Mrs. Vanderzalm and other members at tea.

On March 25 we were in Saginaw accompanied by Mrs. Peterson as house guests of Mrs. L. C. Harvie at her lovely new home attending the joint meeting of Bay and Saginaw Counties. A delightful program was planned and I can recommend Miss O'Brien, Dr. O'Brien's daughter, as a speaker on "What is New to Read," also Mrs. Hutchinson and her beautiful selection on the harp. Then to Lapeer for dinner, and to organize that night.

On April 8 at the Wayne County Meeting to make plans for the State meeting with Mrs. A. O. Brown, convention chairman, and Mrs. Bookmeyer, co-chairman, also Mrs. Whitney and Mrs. Geib. We were fascinated by the profusion of flowers and the gorgeous arrangement of bouquets following the talk on "Gardens and Health" by Professor Paul R. Krome of the Michigan State College, and then a cup of tea.

On April 13 we met Dr. Collisi, Advisory Council chairman, to discuss matters of business and plans for the convention, and attended Kent County's program at Mrs. Leon DeVel's home, after which we were refreshed with a cup of tea before leaving for home.

On April 22 I am happy and proud to announce Washtenaw County organized at a luncheon meeting held at the League.

This county with Lapeer and Fremont will add greatly to our membership and strengthen our State Auxiliary. Thanks to organization Chairman, Mrs. Henry Pyle, and those who preceded her, also the County Medical Societies for their interest.

On May 3 we join the guests of the Calhoun County Auxiliary for luncheon at the Country Club in Battle Creek.

I am happy to share the memories and anticipation of these meetings with you as members of the Auxiliary.

With the usual promptness of the board members in submitting reports for the year, I am sure to have my state report to Mrs. Keck on time, and then complete arrangements to be your delegate at the national meeting in San Francisco from June 13 to 17.

May I urge all doctors' wives in the state to plan to attend the state meeting, as all general sessions are open. Our program will be announced in the July issue of THE JOURNAL.

I will include the article to be printed in supplement to the *California State Journal* as a courtesy for delegates to the national meeting. I could not include all activities of all auxiliaries so selected and placed those which might be of most value to other states. I hope you will approve.

The Nominating Committee has been appointed as follows: Mrs. L. C. Harvie, Chairman, Mrs. E. S. Peterson, and Mrs. Ledru Geib.

If you have names for new officers, please send them to Mrs. Harvie.

Mrs. G. C. Hicks,  
*President Woman's Auxiliary.*

### Ingham County

The Woman's Auxiliary gave a dessert bridge in March at the home of Mrs. T. I. Bauer, Wildwood Drive, East Lansing. A St. Patrick's Day motif was carried out in decorations of spring flowers and tapers. Four prizes were won, and a door prize and traveling prize were also presented. The committee in charge was Mrs. R. E. Loree, Mrs. William Cameron, Mrs. Fred Huntley and Mrs. H. A. Miller.

Mrs. P. C. Strauss,  
*Press Chairman.*

### Eaton County

After the regular March business meeting of the Auxiliary, Miss Cooper and Miss Cox, nurses from the W. K. Kellogg Foundation, were introduced. Miss Cooper gave a very interesting and instructive talk on the work that will be done by the Eaton County Nursing Clinic. She explained that it will be an out-patient service from the Hayes-Green Hospital obtainable by anyone through his own doctor. The service will be in operation after April 15.

Members of the Auxiliary brought gifts for a layette which were very gratefully received by the nurses. The project started by the Auxiliary of giving to the Nursing Clinic will be continued each month.

### Wayne County

On January 12, the Woman's Auxiliary sponsored a "Bring Your Husband Dinner" at the Wardell Hotel. The revival of this dinner met with hearty response as there were one hundred and fifty present. We were most fortunate in having as our honored guest speaker, Mrs. Augustus S. Kech, president of the American Medical Association Auxiliary.

The regular January meeting was held on Friday, January 14, at the medical society headquarters. Dr. Milton Simpson, Professor of Literature at Kalamazoo College, spoke on "The Relation of the Physician to Literature," and referred to the many literary books written by doctors and about doctors. Following the program, tea was served. In February, our social chairman, Mrs. Galen B. Ohmart, and our program chairman, Mrs. Alexander Cruikshank, arranged a luncheon and musicale at the Colony Town Club. Our Ways and Means Committee, Mrs. Richard B. Connelly, chairman, arranged a Floral Bridge Tea on February 18, to raise funds to supply all the Wayne County Schools with *Hygeia*. Cut and potted flowers were displayed all through the club house and were auctioned off by Dr. Martin Hoffman. The committee reported that \$135 had been cleared.

The regular monthly meeting was held on March 11. Due to the absence of our president, Mrs. Roger V. Walker, the first vice president, Mrs. Ledru O. Geib presided. Dr. Maude Watson, director of the Children's Fund of Michigan, was our guest speaker. Her subject was "What Has Mental Hygiene to Contribute to the Intelligent Handling of Children?"



## IN MEMORIAM

Tea was served in the lounge with Mrs. Herman Scarney and Mrs. Wadsworth Warren as hostesses.

HELEN R. DOUB,  
*Press Chairman.*

### Monroe County

The Woman's Auxiliary met for a joint meeting with the Monroe County Medical Society on March 17. Following the dinner a lecture on "The Fads and Quackery in Cosmetics" was given by Dr. Warren Babcock of Grace Hospital, Detroit. The lecture was public and was followed by his showing a series of colored slides provided by the A.M.A.

(MRS. VINCENT) MARTHA BAKER,  
*Press Chairman.*

### Kent County

On February 9 at the regular monthly meeting of the Woman's Auxiliary, Dr. John Lavan, the Health Officer, gave a lecture on "Food Handling Facts." He explained the Food Ordinance, discussing the compulsory health examinations, the laws of sterilizing china and glassware in eating places, and the manner of assigning the red, blue and gold stars to restaurants.

Dr. Wm. J. Butler was the speaker at the meeting March 9. His subject was "Venereal Disease Problems." On March 29, the auxiliary coöperated with the Woman's Field Army of the American Society for the Control of Cancer in giving a benefit bridge to raise money so that a free lecture can be given to the people of this county. The women gave splendid coöperation to this project.

(MRS. ROBERT) MIRIAM ADAMS EATON,  
*Press Chairman.*

### Kalamazoo County

Mrs. John MacGregor entertained the Auxiliary in her beautiful new home at Parchment on March 15. Thirty-three members and two guests were present. The guests enjoyed being shown through the attractive rooms whose beauty had been added to by the presence of roses and spring flowers arranged in lovely bouquets.

After a bountiful coöperative dinner a short business meeting was held. Mrs. Lang announced that our society had been chosen to sponsor the local programs for National Cancer Week and Mrs. Jennings had been appointed to take charge of the activities.

The later evening was spent informally.

(MRS. HUGO) BARBARA AACH,  
*Publicity Chairman.*

### Jackson County

The regular meeting of the Women's Auxiliary was held Tuesday evening, March 15, at the home of Mrs. Frank Gibson, 2053 Wildwood Lane. A 6:30 dinner was served to the members present by a committee composed of Mesdames Corwin, Clark and John Wholihan, co-chairmen, John Van Schoick, C. D. Munro, M. N. Stewart and E. O. Leahy.

The president, Mrs. Ludwick, conducted a short business meeting, at which time it was reported that the money for our year's project has been more than raised. A petition was circulated and signed favoring a bill that April be declared National Cancer Control month.

A report from the nominating committee, composed of Mesdames Bullen, Clark and Hurley was read.

Mrs. Page, program chairman, then introduced the speaker of the evening, Miss Elizabeth Camburn. Her subject was "The Story of a Pioneer," the life of Dr. Anna Howard Shaw. Dr. Shaw, born in England, came to this country at a very early age,

and grew up to young womanhood in a log cabin in Michigan. During the World War, she was called to Washington, and from there organized the women of the United States to service, such as that of the Red Cross. She became one of the most distinguished women of this country. In her we had a reformer who was extraordinarily sane and tolerant. She was about five feet in height, had snow white hair, beautiful dark eyes, and looked most charming in her pulpit robes.

ANNA HYDE SHAEFFER,  
*Press Chairman.*

## IN MEMORIAM

### Daniel Waldo Fenton, M.D.

Dr. Daniel Waldo Fenton of Reading, Michigan, died on January 7, 1938, of chronic myocarditis. Dr. Fenton was dean of the medical profession in Hillsdale County. He was born in Delaware County, Ohio, in 1848, and attended school in Galena, Ohio, and Fremont, Indiana. After studying medicine at the University of Michigan for two years, Dr. Fenton transferred to the Detroit College of Medicine, where he received his degree in 1876. He began practice in Angola, Indiana, the same year, and therefore had been practicing medicine for sixty-two years. In 1887, Dr. Fenton located at Reading, Michigan. Dr. Fenton served as Secretary-Treasurer of the Hillsdale County Medical Society for eighteen years. He was elected President Emeritus of the Hillsdale County Medical Society in 1937, and he was a member emeritus of the Michigan State Medical Society, 1937, and fellow of the American Medical Association. Dr. Fenton is survived by his daughter, Hazel Fenton Schermerhorn, his brother-in-law, John Thompson, and several cousins.

### Dr. Lewis S. Potter

Dr. Lewis S. Potter died on April 19, at his home in Detroit following a brief illness. He was born at Maidstone, Ontario, forty-eight years ago, and lived in Detroit for thirty-one years. Dr. Potter was graduated from the Detroit College of Medicine, and for many years was a staff member of Providence Hospital. He is survived by his wife, Agnes, a daughter, Betty, and three sons, George, William and Theodore, also three brothers, Dr. Andrew, Dr. Willis and Fred Potter, and two sisters, Mrs. Fred Whitman and Mrs. William Hyland.

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LANSING, MICHIGAN

**SMALLPOX**

Smallpox continues to spread in the state, occurring with considerable frequency in new localities. The total number of cases this year has been relatively small, although the incidence since January 1 is considerably more than for several years. Many of the cases have been so very mild and the lesions so few that either a physician has not been called or the disease has been overlooked. This has occurred in a number of communities so that cases have existed for several weeks and numerous exposures have occurred before the disease was discovered. Thus it has spread to many different localities, having occurred since January 1 in the following counties: Alger, Berrien, Branch, Calhoun, Dickinson, Genesee, Gogebic, Houghton, Iron, Kent, Marquette, Menominee, Monroe, Oakland, Ogemaw, Ontonagon, Ottawa, Washtenaw and Wayne.

**TO SURVEY MICHIGAN'S  
HEALTH SERVICES**

Michigan's state and local health organizations, both official and voluntary, will be surveyed by the State Health Studies Committee of the American Public Health Association under the direction of Dr. Carl E. Buck, field director.

The survey had been requested by Governor Frank Murphy and Dr. Don W. Gudakunst. Dr. Buck expects to begin his study in Michigan about June 1. He will be assisted by Dr. G. F. Amyot, adminis-

trative associate. Survey offices will be maintained in Lansing.

Scope of the survey will include an analysis of health services now being carried on by the State Department of Health, other state departments carrying on health activities, local health departments, educational institutions and voluntary health agencies. Gaps in Michigan's health program will be analyzed and recommendations made to meet these needs.

The survey will be made without cost to Michigan. The selection of Michigan as the next state to be studied was voted by the recent session of the A.P.H.A. committee in New York. Florida will be the next state to be surveyed following the Michigan study.

**WEIL'S DISEASE**

Outbreaks of epidemic jaundice appear to be more numerous during the last year than in previous times. It is true that we have had knowledge of such outbreaks during at least the last two generations. Little attention has been given to this disease by public health workers. Outbreaks of what appear to be a communicable form of jaundice have occurred during the last year in the following Michigan localities: Antrim, Berrien, Oakland, Ionia, Clinton, Jackson, Washtenaw and Monroe Counties, and the City of Detroit.

Little of the epidemiology has been worked out in connection with these outbreaks. The etiology has not been proved except in two or three instances. The specific cause of epidemic jaundice about which we know something is the same as that of Weil's disease, the causative organism of which is leptospira icterohemorrhagiae. While a number of investigators have been working on this disease and several articles have appeared in the literature, yet relatively

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little is known so far of the incidence of the disease, the method of spread, and the prevalence of the organism.

Rats are known to carry the infection. The organism is eliminated in the urine of both rats and humans. Dogs have been found to be affected and to play a part, although just what part is as yet somewhat uncertain.

Recently an outbreak occurred in Detroit in which there was one fatality. This outbreak is being investigated and will be reported by epidemiologists of the Detroit Department of Health.

During March a request was made by the Michigan Department of Health to the U. S. Public Health Service for the aid of a consultant to study the disease in Michigan. Dr. A. Packchianian was sent to Michigan for this purpose. He has collected laboratory samples in several outbreaks and has given some attention to the epidemiology. The studies are not yet completed. If they prove at all promising, it is likely that they will be carried on for some time. The epidemiology of the disease does not appear to be simple and will probably require much work before any definite conclusions can be drawn. Dr. Packchianian has already established the etiology of a few of the cases in the Detroit outbreak as being the leptospira icterohemorrhagiae.

One handicap in the investigations has been the difficulty in locating cases of what appear to be infectious jaundice during the acute stage when it is possible to obtain positive blood and urine cultures. Dr. Packchianian conservatively reserves judgment as to whether the outbreaks which have been occurring in Michigan are due entirely, or for the most part, to leptospira icterohemorrhagiae. Physicians are requested to report promptly to the local health officer any cases that appear to be epidemic jaundice.

## CHILDREN'S DENTISTRY

Detailed instruction of practicing dentists in the importance and technic of children's dentistry will be carried on at selected centers throughout the state as a part of the Michigan maternal and child health program. Plans for the postgraduate instruction in children's dentistry are now being worked out under the direction of Dr. William R. Davis, director of the Bureau of Mouth Hygiene. He is being assisted by Dr. U. G. Rickert, president of the State Dental Society; Dr. Paul H. Jeserich, director of the postgraduate work of the University of Michigan School of Dentistry; and representatives of the W. K. Kellogg Foundation and the Children's Fund of Michigan.

Outstanding authorities in the field of children's dentistry are being secured to conduct the courses in cooperation with the local dental societies. The postgraduate courses will get under way early in the fall.

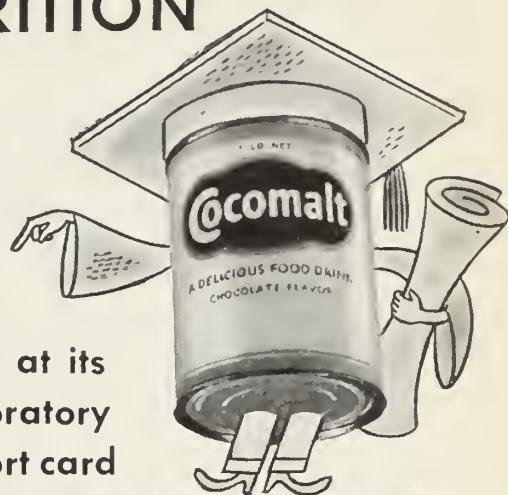
## POSTGRADUATE COURSE IN PEDIATRICS

Physicians of northern Michigan will be offered a postgraduate course in pediatrics starting the week of May 2 as another phase of the Michigan maternal and child health program, it has been announced by Dr. Lillian R. Smith, director of the Bureau of Maternal and Child Health.

The course will be given at Grayling, Traverse City, Petoskey and Alpena on successive nights each week for four weeks. Dinner meetings will be held at each center to be followed by lectures and discussion. Physicians may attend the instruction center most conveniently located near them. There is no charge for the course.

The first series of lectures will be conducted by Dr. John L. Law, instructor in pediatrics and infectious diseases at the University of Michigan Hospi-

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tal. His subject will be "Management of meningitis, erysipelas, scarlet fever, and streptococcus infections in general with particular reference to the use and abuse of sulphanilamide."

Dr. W. C. C. Cole of Detroit Woman's Hospital will conduct the postgraduate lectures the week of May 9 on the subject of "Nontuberculous infections in the respiratory track as they occur in infancy and childhood."

The week of May 16 Dr. James Wilson of Detroit Children's Hospital will discuss "The newborn period: asphyxia (rôle of analgesic in production of), resuscitation, hemorrhage, atelectasis and other conditions of the newborn."

Dr. J. A. Johnston, pediatrician-in-chief at Detroit Henry Ford Hospital, will give the final series of lectures. His topic is "Nutritional studies in infancy and childhood; comparative study of various types of infant feeding; diet requirements in the older child and the adolescent; relation between infection and nutrition."

### Seeking a Job

The editor of the *Malaya Tribune*, Selangor, F.M.S., received the following letter from a native who was applying for a position:

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"I asking for job. I can do any kind of works by virtue of my flexible brain and very advanced training. I passed matriculation in a very large college in —.

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"If your honor will be good enough to employ me, I will in duty bound always pray for your honor's long life. My prayers have always been heard as I always pray very loud. If wanting my services, I can come suddenly. Putting myself at your honor's large feet, I pray to become your honor's humble and faithful servant. I remain, Your Godsend servant."

—*Efficiency Magazine*.

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## ◆ General News and Announcements ◆

### *The One Hundred Per Cent Club of the Michigan State Medical Society*

1. Barry County Medical Society
2. Cass County Medical Society
3. Clinton County Medical Society
4. Delta County Medical Society
5. Dickinson-Iron County Medical Society
6. Eaton County Medical Society
7. Gogebic County Medical Society
8. Hillsdale County Medical Society
9. Houghton-Baraga-Keweenaw County Medical Society
10. Ingham County Medical Society
11. Jackson County Medical Society
12. Lapeer County Medical Society
13. Lenawee County Medical Society
14. Livingston County Medical Society
15. Luce County Medical Society
16. Manistee County Medical Society
17. Mecosta-Osceola County Medical Society
18. Menominee County Medical Society
19. Muskegon County Medical Society
20. Newaygo County Medical Society
21. O.M.C.O.R.O County Medical Society
22. Oceana County Medical Society
23. Ontonagon County Medical Society
24. Saginaw County Medical Society
25. Schoolcraft County Medical Society
26. Shiawassee County Medical Society
27. Tuscola County Medical Society.

These county medical societies have recorded 100 per cent paid membership for the year 1938. Is your county society listed above? Several societies have reported dues for all their members except one or two. If your dues are unpaid, please contact your county secretary today; you may be able to put your society in the 100 per cent classification.

*"You cannot make the burden of civilization too great."*—A.McL., Detroit.

\* \* \*

*The Lenawee County Medical Society* heard Dr. Robert S. Breakey of Lansing on April 19. Doctor Breakey spoke on the subject of "Syphilis."

\* \* \*

*Dr. Ralph H. Pino* of Detroit addressed the members of the Saginaw County Woman's Auxiliary on April 21 on the subject "Conservation of Eyesight."

\* \* \*

*"Depression is that period when we do without some of the things our parents never had."*—J.M.R., Detroit.

\* \* \*

*Dr. Henry R. Carstens* of Detroit, chairman of the Finance Committee of The Council, M.S.M.S., has been enjoying a vacation at Miami, Florida.

\* \* \*

*Modern definition of "technic":* "Doing the simplest things with the greatest difficulty."—V.M.M., Grand Rapids.

\* \* \*

*Dr. Gordon Myers* of Detroit spoke to the members of the Wexford County Medical Society at Cadillac on March 31. His subject was "Sulfanilamide."

\* \* \*

*Dr. Phillip Howard*, Detroit, spoke on the subject "Convulsive Disorders of Infancy and Childhood" before the Lapeer County Medical Society on April 21, in Lapeer.

*The Glee Club* of the Wayne County Medical Society presented its Fifth Annual Concert in the Main Auditorium of the Detroit Institute of Arts on April 25.

\* \* \*

*Chiropractor pleads guilty.*—J. J. Robbins, a chiropractor of Mason (Ingham County), Michigan, pled guilty on April 12 to a charge of practicing medicine without a license. Photostatic copies of a sign which read "Dr. J. J. Robbins" were produced in court.

\* \* \*

*Dr. Loren W. Shaffer*, chairman of the Advisory Committee on Syphilis Control of the M.S.M.S., appeared on Wednesday, April 13, before the Oakland County Medical Society. His subject was "The Michigan Program of Syphilis Control."

\* \* \*

*You owe much of your medical security today* to the past activities of organized medicine. You have an obligation to those who follow. Will you help carry on? Your destiny is intimately related to the success of your county, state and national medical organizations.

\* \* \*

*"State Society Night"* will be celebrated by the St. Joseph and Branch County Medical Societies at Coldwater, on May 11. The O.M.C.O.R.O County Medical Society was host to the officers of the Michigan State Medical Society at a "State Society Night" program on April 27 in Gaylord.

\* \* \*

*Dr. Douglas Donald*, Professor of Medicine, Wayne University, Detroit, addressed the St. Clair County Medical Society at its meeting of April 19 held at the Chateau in Port Huron. His subject was "Pain in the Cardiac Area Not Due to Coronary Disease."

\* \* \*

*The Gratiot-Isabella-Claire County Medical Society* and the Dental Society held a joint meeting in Alma on April 21. Dr. Arthur C. Curtis of the Department of Internal Medicine, University of Michigan, was guest speaker. His subject was "Focal Infections."

\* \* \*

*Speed Trap:* Physicians driving through Webberville, on U. S. 16 (between Detroit and Lansing), are warned to cut their speed to 20 miles per hour, as numerous complaints have been registered with the A.A.A. concerning the jealousy of Webberville's town marshal.

\* \* \*

*"Does your firm advertise in THE JOURNAL of the Michigan State Medical Society and does it exhibit at the annual conventions of the M.S.M.S.?"* Ask this question of all detail men who call upon you seeking your patronage.

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\* \* \*

*The State Compensation Officer* of the Michigan Works Progress Administration at Lansing announces to the medical profession that treatment of hernia by the injection method is not authorized by the United States Employees' Compensation Commission, and will not be paid for by said commission.

*Dr. Stanley Leszynski* of Detroit and *Dr. Francis J. O'Donnell* of Alpena have been appointed by the Governor to serve as new members of the Michigan State Board of Registration in Medicine. Drs. Eugene S. Thornton of Muskegon, Harold L. Morris of Detroit and John J. Walch of Escanaba have been reappointed as Board members.

\* \* \*

Governor Frank Murphy has appointed four members to the State Board of Examiners in Basic Sciences. The Basic Science examinations will be in those subjects basic to all the healing professions. The appointees are all teachers who are not engaged in the actual practice of any of the healing arts. They consist at the present of Dr. W. O. Nelson of Wayne University, Dr. J. P. Haitams of Calvin College, Grand Rapids, the Rev. Father George Shiple of the University of Detroit, and Dr. Ralph C. Huston of Michigan State College. Another member of the Basic Science Board will be selected, according to a newspaper item, from nominations from the chiropractors. Departments in which the examinations will be held are physiology, anatomy, bacteriology, hygiene and public health, and chemistry.

\* \* \*

*Dr. Milton Shaw*, Lansing, immediate past-president of the Ingham County Medical Society, was presented with a silver tray upon which was engraved the signature of every member of the Society. The award was given in appreciation of the service Doctor Shaw has rendered the medical profession and the community in the past.

\* \* \*

*The Detroit Tigers* will be at home in Detroit prior to, during, and immediately after the 1938 annual meeting of the Michigan State Medical Society next September:

*September 15, 16, 17—playing New York*

*September 18, 19—playing Washington*

*September 20, 21—playing Philadelphia*

*September 22, 23, 24, 25—playing Cleveland*

\* \* \*

Requests are being received almost daily by the Michigan State Medical Society Placement Bureau

from young physicians who desire to find suitable locations. Already three physicians have been assisted by the Bureau to find good locations to practice. Anyone who needs an assistant or who knows of a community where another physician is needed, is invited to communicate with the Placement Bureau, M.S.M.S., 2020 Olds Tower, Lansing.

\* \* \*

*San Francisco invites you.*—On June 13, the American Medical Association's Annual Convention will convene in the Coast City. Physicians who plan to attend this great scientific exposition should secure hotel reservations at once. Write or wire Dr. F. C. Warnshuis, 450 Sutter Street, San Francisco. Give the names of members of your party, type of accommodations required, rates, dates of arrival and departure.

\* \* \*

Members of the Michigan State Medical Society are cordially invited to join the Chicago Medical Society Special to the American Medical Association Convention in San Francisco. The special leaves Chicago on June 9, 1938, at 9:00 p. m. and arrives in San Francisco at 8:30 a. m., Sunday, June 12. For further information, address Dr. Victor L. Hitzfeld, chairman, Train Arrangements, Chicago Medical Society, 30 North Michigan Ave., Chicago, Ill.

\* \* \*

*Some untested drugs*, like elixir of sulfanilamide, have proven deadly to patients and ruinous to a physician's reputation.

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\* \* \*

*The Upper Peninsula Medical Society* will meet in Sault Ste. Marie on August 17 and 18, 1938. The Program Committee, of which Dr. F. C. Bandy of Sault Ste. Marie is chairman, is arranging a quality program for the two-day convention, which will

# The Forty-ninth Annual Reunion

and

## Detroit Clinics

of the Alumni Association of Wayne University

College of Medicine

will be held at Detroit, June 15 and 16, 1938



include a talk by Dr. W. W. Bauer of the American Medical Association, and also a symposium on "The Socio-Economic Problems of Medicine."

The complete program of the Upper Peninsula meeting will be published in succeeding issues of THE JOURNAL.

\* \* \*

State Health Commissioner Don W. Gudakunst and Dr. C. C. Young, Director of the Laboratory, extend an invitation to all County Societies of the State to visit the Laboratory, located just outside of Lansing. Any Society wishing to accept this invitation may write Doctor Gudakunst and make all necessary arrangements. A visit to the Laboratory is very worthwhile; the amount and type of work done by the State Health Laboratory is not realized until one visits the plant.

\* \* \*

The Wayne County Medical Society has publicized in the daily newspapers in Detroit the fact that medical care is available for every resident of Wayne County regardless of his economic circumstances. Each member of the medical profession has been supplied with an elaborate diagram supplying correlated information showing how each person may receive medical care that he or she needs. If the patient is unable to pay anything, it is supplied. If he can meet the cost in deferred payments, he is shown how this may be done.

\* \* \*

Mr. George T. Gundry, Auditor General of Michigan, has written the following relative to the Michigan State Medical Society's Filter System, created to help control intake under the Afflicted-Crippled Child Acts:

"The Medical Filter Committee is doing a difficult job with splendid results on a strictly gratuitous basis. Therefore, this office is desirous at all times of co-

operating in every way with the Medical Filter Committee in its various duties, and we will never advocate any procedure which circumvents the work of that committee."

\* \* \*

*Crippled and Afflicted Child Commitments* for the month of March, 1938, were as follows: Crippled Child: Total of 354 of which 155 went to University Hospital; and 199 went to miscellaneous hospitals. Of the above, Wayne County wrote 110 orders of which 31 went to University Hospital and 79 went to miscellaneous hospitals.

Afflicted Child: Total of 2,200 of which 295 went to University Hospital; and 1,905 went to miscellaneous hospitals. Of the above, Wayne County wrote 632 of the orders, of which 37 went to University Hospital and 595 went to miscellaneous hospitals.

\* \* \*

Two "refresher courses" have been arranged by the Michigan Crippled Children Commission for physicians in the neighborhood of Bay City and Ironwood.

Dr. John Law of Ann Arbor and Dr. A. D. LaFerte of Detroit conducted the course in Bay City on May 11. Dr. Law's subject was "Pediatric Problems," and Dr. LaFerte spoke on "Fractures of the Neck of the Femur."

On May 23, a "refresher" will be given in Wakefield, Gogebic County, for all physicians of the upper Peninsula. Dr. E. R. Elzinga of Marquette will speak on "Fractures of the Hip," and Dr. M. Cooperstock will present "Treatment in Pediatrics."

\* \* \*

Dr. Harold A. Miller of Lansing spoke before the Community Lecture Committee, Eaton Rapids High School, on the subject of "Adolescence" on March 10. On March 21, he addressed the Parent-Teacher

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Association of Lapeer on the subject of "Problems of Sex Education in High Schools."

"Social Disease with Its Implications" was the subject of his lecture on the Parent Institution Program held in Reading on March 30. The Thumb Association of Child Study Club, Sandusky, scheduled Doctor Miller on May 18 to speak on "Sex Education in High Schools." Doctor Miller's lectures are given under the auspices and sponsored by the Joint Committee on Health Education.

\* \* \*

Dr. C. D. Munro of Jackson was honored recently by members of the Jackson County Medical Society when the Society presented to the Board of Managers of Foote Memorial Hospital, Jackson, a bronze plaque on which is embossed the profile and a testimonial to Dr. Munro. Dr. John D. Van Schoick, President of the Jackson County Medical Society, presented the plaque to Chairman H. D. Burton of the Hospital Board. Dr. Munro is a past president of the Jackson County Medical Society and former chairman of the surgery section of the Michigan State Medical Society. Dr. Munro has a son, Nathan, who is a sophomore in the medical school at the University of Michigan.

\* \* \*

*Your friends*—The following firms are some more of your friends who entered technical exhibits at the 1937 Grand Rapids Convention. Products of these firms are Council approved and are worthy of your consideration:

Randolph Surgical Supply Company, Detroit, Mich.  
E. J. Rose Manufacturing Company, Detroit, Mich.  
W. B. Saunders Company, Philadelphia, Pa.  
E. R. Squibb & Sons, New York City  
Standard X-Ray Equipment Company, Detroit, Mich.  
Van Hoosen Farm, Rochester, Mich.  
Wall Chemicals, Inc., Detroit, Mich.  
Western Electric Hearing Aids, Detroit, Mich.  
The Zemmer Company, Pittsburgh, Pa.  
The Zimmer Manufacturing Company, Warsaw, Indiana.

\* \* \*

The Wayne County Medical Society received many lines of favorable publicity in Detroit newspapers as a result of its statement to the public "If you need medical care, see your physician. He will see that you get it."

One newspaper carried the following announcement, prominently displayed:

IF YOU NEED MEDICAL CARE  
AND DO NOT KNOW HOW TO GET IT  
WRITE AT ONCE TO  
WAYNE COUNTY MEDICAL SOCIETY  
4421 WOODWARD AVENUE  
DETROIT

This activity represented the first step in the Wayne County Medical Society's study of medical needs, in conformity with the A.M.A. Survey.

\* \* \*

The Third Anniversary Meeting of District Department of Health No. 6 (Luce and Mackinac Counties) was held on April 1 in Newberry. Over 300 attended the afternoon public meeting. More than 100 teachers and nurses attended the round table discussion in the morning. All the members of the staffs of the nine health units in the Upper Peninsula were present. Among the speakers were Dr. Don W. Gudakunst, State Health Commissioner, Dr. Loren W. Shaffer, Detroit, chairman of the M.S.M.S. Advisory Committee on Syphilis Control, and Dr. Clare Gates, field secretary of the Joint Committee on Health Education. Dr. F. C. Bandy of Sault Ste. Marie, Councilor of the State Medical Society, acted as chairman of the afternoon program.

MAY, 1938



## DIET

When the impulse to defecate is lessened due to improper diet or lack of discipline, the fecal matter usually becomes dehydrated and impacted in the bowel . . . To simplify the problem of bowel regularity, Petrolagar may be prescribed to advantage, as it assists in the regulation of bowel movement. Petrolagar mixes intimately with the bulk of the stool to induce a soft, easily passed mass. By reason of its pleasant taste and mild but thorough action, Petrolagar is agreeable to patients of all ages. Five types of Petrolagar provide a choice of laxative medication suitable for the individual patient. Petrolagar Laboratories, Inc., 8134 McCormick Blvd., Chicago, Ill.

Petrolagar . . . Liquid petrolatum  
65 cc. emulsified with 0.4 Gm. agar  
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**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technic with practice on living tissue; Clinical Course; Special Courses. Courses start every Monday.

**GYNECOLOGY**—Personal Courses May 2nd, June 13th, August 22nd. Gynecological Pathology by Dr. Schiller starting July 25th.

**OBSTETRICS**—Two Weeks Intensive Course starting June 6th; Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course; Intensive Formal Course starting June 6th.

**UROLOGY**—One Month Course; Two Weeks Course starting every two weeks.

**CYSTOSCOPY**—Ten Day Practical Course Rotary every two weeks.

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*Official Call* to the Officers, Fellows, and Members of the American Medical Association: The eighty-ninth annual session of the American Medical Association will be held in San Francisco, California, from Monday, June 13, to Friday, June 17, 1938.

The House of Delegates will convene on Monday, June 13.

The Scientific Assembly of the Association will open with the General Meeting held on Tuesday, June 14, at 8:30 p. m.

The various sections of the Scientific Assembly will meet Wednesday, June 15, at 9 a. m. and at 2 p. m. and subsequently according to their respective programs.

J. H. J. UPHAM, M.D., *President*

NATHAN B. VAN ETEN, M.D.

*Speaker, House of Delegates*

OLIN WEST, M.D., *Secretary.*

\* \* \*

*The Medical Society of the State of New York* has developed a "Hand Book Series," as a part of its Speaker's Bureau activity. The series includes monthly bulletins covering particular subjects for dissemination to the public by physicians who have indicated their willingness to address lay audiences in behalf of health education.

Dr. Charles H. Goodrich, president of the Society, states: "It is required of us in all loyalty to our people and to each other to *increase our platform appearances* and to provide for systematic covering of the many truths which the people should know and concerning which they are being deceived by gilded sophistries and false promises."

\* \* \*

*Healers refused the title of "Doctor" in Ontario.*—A bill which sought the title of "doctor" for osteopaths, chiropractors and recognized drugless practitioners was thrown out by the Private Bills Committee of the Ontario Legislature, on March 29. According to the *Toronto Daily Star*, "provincial police had to be called to make a path for Dr. Herbert Bruce through the hallway outside the committee room, which was jammed by supporters of the drugless practitioners. They jostled the former lieutenant-governor and called insulting remarks at him."

"It was immediately after Dr. Bruce's plea against the bill that the committee overwhelmingly disposed of it."

\* \* \*

THE JOURNAL of the Michigan State Medical Society has played no small part in the progress of Michigan medicine to its present estimable position. Today THE JOURNAL with its excellent presentation of original research, special articles, committee reports and county society activities ranks with the outstanding state society publications. As a promoter of society unity, THE JOURNAL serves to weld together Michigan medicine in an integrated program for conserving the health of the citizens of this state. Dr. J. H. Dempster and the publication committee of the society are to be congratulated on the fine service they are rendering their profession and, consequently, all the people of Michigan.—*Michigan Public Health*, February, 1938.

\* \* \*

*The employed person in the United States* wants a job and the health to keep on the job. He does not want to lose any time due to sickness. He knows that in Germany, under a health insurance system, time lost through sickness by insured workmen trebled in fifty years. In England the time lost increased from nine days, before compulsory insurance went into effect, to *twelve and one-half days per man yearly after the system was in operation.*

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## PLAN NOW TO ATTEND

The most important event of 1938 in Industrial  
Medicine and Occupational Diseases

23rd Annual Meeting

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DISEASES

**PALMER HOUSE, Chicago, June 6-7-8-9, 1938**

A well rounded program of lectures, demonstrations and round table discussions is planned. Everything humanly possible will be done to make your visit one of profit, pleasure and comfort. Mark the dates on your calendar and plan to attend.

For further information write to

A. G. PARK, Convention Manager

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The comparison with American figures is striking, for the average loss of time by our own workmen is only about six and one-half days a year, and the figures have been stationary at that level for twenty-five years, and under a system of private medical practice!

\* \* \*

*The Medical School Seminar* at the 41st Annual Meeting of the Associated Harvard Clubs, will be held at the Palmer House, Chicago, Saturday, May 21, at 2:30 p. m. immediately following a joint luncheon of all the schools. Those on the program of the Medical Seminar include Dr. C. Sidney Burwell, Dean and Research Professor of Clinical Medicine, Harvard; Dr. A. Baird Hastings, Hamilton Kuhn Professor of Biological Chemistry; Dr. Walter Bauer, Associate Professor and Tutor in Medicine; and Dr. Elliott C. Cutler, Moseley Professor of Surgery.

All graduates of the University are invited to attend. Admission cards are available to non-Harvard men; address Dr. Willard O. Thompson, 700 North Michigan Avenue, Chicago, Ill.

\* \* \*

*The Michigan Department of Health*, the University of Michigan Department of Postgraduate Medicine, the Michigan State Medical Society and the Michigan Branch of the American Academy of Pediatrics are sponsors of the second series of postgraduate lectures in pediatrics in four centers, Alpena, Petoskey, Traverse City, and Grayling, once a week for four weeks, now in session.

The weekly schedule of lectures is as follows: Monday, Grayling, Mercy Hospital, 6:00 p. m.; Tuesday, Alpena, Owl Cafe, 6:00 p. m.; Wednesday, Petoskey, Hotel Perry, 6:00 p. m.; Thursday, Traverse City, Central Michigan Children's Clinic, 4:00 p. m.

The program: *Week of May 2*—Dr. John Law, Ann Arbor. Management of meningitis, erysipelas, scarlet fever, and streptococcus infections in general with particular reference to the use and abuse of sulfanilamide. *Week of May 9*—Dr. W. C. C. Cole, Detroit. Non-tuberculous infections in the respiratory tract as they occur in infancy and childhood. *Week of May 16*—Dr. James Wilson, Detroit. The newborn period; asphyxia (rôle of analgesic in production of), resuscitation, hemorrhage, atelectasis and other conditions of the newborn. *Week of May 23*—Dr. J. A. Johnston, Detroit. Nutritional studies in infancy and childhood; comparative study of various types of infant feeding, diet requirements in the older child and the adolescent; relation between infection and nutrition.

\* \* \*

#### American Express Tour to A.M.A.

Physicians and their families are evincing a very keen interest in arrangements made by the American Express Travel Service to see America en route to and returning from the San Francisco Convention of the A.M.A.

The beauty and relaxation of such scenes as the Indian Detour in New Mexico, the Grand Canyon of Arizona, Los Angeles and the beauties of southern California, Santa Catalina Island, the famous Columbia River Highway in Oregon, Seattle, Washington, Victoria, Vancouver, Lake Louise and Banff in the Canadian Rockies, Yellowstone National Park, Colorado Springs and many others, will be enjoyed.

An attractive folder, describing these travel arrangements and giving the all-inclusive price, may be obtained from American Express Travel Service, 1227 Washington Blvd., Detroit, Michigan.

MAY, 1938



## What have you to gain by prescribing S.M.A.?

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- S. M. A. produces excellent nutritional results simply and quickly.
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Convince yourself. Prescribe S. M. A. and compare the results with your present methods. You will find, as have thousands of other physicians, that S. M. A. offers added advantages to you, to the mother, and to the infant.

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\* \* \*

Organizational talks by officers and by the Executive Secretary of the Michigan State Medical Society during the past month include:

Federal Health Program.—"Though details won't be announced for some time, New Deal leaders have drafted plans for a large-scale national health program to be financed by the Federal Government. The first move calls for a national health conference—probably in early fall."—*The Periscope in News Week*, March 14, 1938.

Speaker	City	Date	Organization	Subject
Dr. P. R. Urmston	Battle Creek	3/22	Calhoun County Med. Soc.	"A.M.A. Survey"
Dr. L. F. Foster	Battle Creek	3/22	Calhoun County Med. Soc.	"A.M.A. Survey"
Dr. L. G. Christian	Battle Creek	3/22	Calhoun County Med. Soc.	Michigan Health League
Wm. J. Burns	Battle Creek	3/22	Calhoun County Med. Soc.	"What the M.S.M.S. is Doing"
Dr. L. F. Foster	Port Huron	4/5	St. Clair County Med. Soc.	"A.M.A. Survey"
Dr. P. R. Urmston	Port Huron	4/5	St. Clair County Med. Soc.	"The Council's Work"
Wm. J. Burns	Port Huron	4/5	St. Clair County Med. Soc.	"Recent Legislative Developments"
Dr. L. F. Foster	Lansing	4/19	Ingham County Med. Soc.	"A.M.A. Survey"
Wm. J. Burns	Lansing	4/19	Ingham County Med. Soc.	"What's Going On"
Dr. L. F. Foster	Udly	4/21	Huron-Sanilac Med. Soc.	"A.M.A. Survey"
Wm. J. Burns	Battle Creek	4/26	Battle Creek Academy of Medicine and Dentistry with Calhoun County Bar Ass'n	"Results from Coöperation"
Dr. Henry Cook	Gaylord	4/27	OMCORO County Med. Soc.	"Preventive Medicine"
Dr. P. R. Urmston	Gaylord	4/27	OMCORO County Med. Soc.	"Work of the Council"
Dr. L. F. Foster	Gaylord	4/27	OMCORO County Med. Soc.	"A.M.A. Survey"
Wm. J. Burns	Gaylord	4/27	OMCORO County Med. Soc.	"Other Activities"
Dr. Henry Cook	Kalamazoo	(noon) 5/11	Kalamazoo Academy of Medicine (Board of Trustees)	"A.M.A. Survey"
Dr. L. F. Foster	Kalamazoo	(noon) 5/11	Kalamazoo Academy of Medicine (Board of Trustees)	"A.M.A. Survey"
Dr. P. R. Urmston	Coldwater	(night) 5/11	St. Joseph-Branch County Med. Societies	"State Society Night"
Dr. F. T. Andrews	Coldwater	(night) 5/11	St. Joseph-Branch County Med. Societies	"State Society Night"
Wm. J. Burns	Coldwater	(night) 5/11	St. Joseph-Branch County Med. Societies	"State Society Night"
Wm. J. Burns	Battle Creek	5/12	Mich. State Nurses Ass'n	"Panel Discussion"
Dr. L. F. Foster	Marquette	5/14-15	Upper Peninsula County Society Secretaries' Conference	"A.M.A. Survey"
Wm. J. Burns	Marquette	5/14-15	Monroe County Med. Society	"Other Activities"
Dr. L. F. Foster	Monroe	5/19	Monroe County Med. Society	"Ethics"
Wm. J. Burns	Monroe	5/19	Monroe County Med. Society	"A.M.A. Survey"

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The Chicago Tumor Institute, chartered in Illinois, not for profit, conducts research on the causes, diagnosis, and treatment of cancer, instructs and assists physicians, surgeons, clinics, and hospitals in the diagnosis and treatment of cancer, and trains cancer specialists.

The two unique features of the Institute are, (1) the assembling of a group of leading cancer authorities from various medical centers of the world to collaborate in the study of the cancer problem, and (2) the formation of an organization devoted exclusively to the study of cancer.

The Institute is equipped with research laboratories and modern x-ray and radium equipment. The former includes two x-ray machines of medium voltage and two of the super-voltage type. The Institute will have at its disposal eleven grams of radium, ten of which will be used in the form of a radium bomb.

\* \* \*

Dr. A. W. Lescohier, who has been for a number of years manager of Parke Davis and Company, has been promoted to the position of president. THE JOURNAL extends congratulations to Dr. Lescohier in this recognition of his ability. A member of the medical profession, the doctor has kept close to the profession. He is an old member of the Wayne County Medical Society and Michigan State Medical Society. Dr. Lescohier was associated with the Research Department of Parke Davis before he was an M.D. He relinquished his position from 1905 to 1909 to attend what is now the Medical School of Wayne University. His course in medical college was brilliant. Following his graduation, in 1909, he returned to Parke Davis where he has remained. His career has been so satisfactory to

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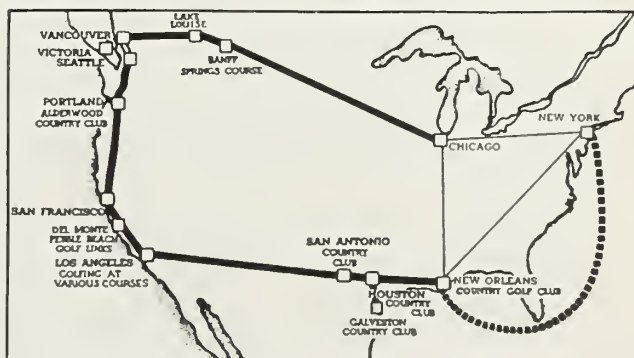
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all concerned that he now holds the highest position in the company. Dr. Lescohier has made many friends among the medical profession not only within Michigan but wherever in his wide business relations he is known.

\* \* \*

All around or part way.—Flexibility marks the "Golfer's Special" itinerary to San Francisco for the 24th Annual Tournament of the American Medical Golfing Association, June 13, 1938. You may join the Tour at three points: (1) at New York, sailing on the luxurious S. S. Dixie to New Orleans, (2) at New Orleans, via rail to Houston, Galveston, San Antonio, Los Angeles, Del Monte, and San Francisco, (3) at San Francisco, for the return journey via rail through the glorious Northwest—Portland, Seattle, (all-day boat trip up Puget Sound), Victoria, Lake Louise and Banff. Non-golfers as well as golfers (and their ladies) are invited to take advantage of this wonderful trip. Write for complete details: Bill Burns, 731 N. Capital Ave., Lansing.





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Heated, circulating air is the agent commonly used in desiccating animal tissues for medicinal use, but in preparing Rabies Vaccine, Lilly, rabies infected brain and spinal cord are dried under exactly opposite conditions—at freezing temperature within a vacuum. Nerve tissue when so treated can be finely pulverized and the contained fixed virus remains unmodified and fully potent even though the powder is stored for a number of years.

Active material of such uniformity and stability may be divided into exact units and a standardized treatment for every suspected rabies infection may be completed with only fourteen doses. Of all persons given preventive inoculations with such Rabies Vaccine, only 0.02 per cent have developed the disease.

\* \* \*

*Taxes payable by individual physicians.*—Under the Social Security Act an employer is liable for certain taxes. There are only a few exceptions to the rule. A physician is in the same position as any one else. If he employs one or more persons not in the excepted class, he must apply for a registration number to the Social Security unit or the tax unit of the Commissioner of Internal Revenue office and get a number for himself as an employer. His employee must do likewise. The physician must make his regular monthly, quarterly and annual returns, paying his own taxes and the tax that he deducts from his employee's salary.

If a physician is an employee, he likewise is liable for taxes under the Social Security Act, and he must like wise apply for and be given a number. A physician who employs only one employee not in the excepted class—a domestic servant for instance, is excepted—is liable for the tax. If he employs a nurse, he is liable. If he employs a secretary, he is liable. If he employs as many as eight persons, or if a hospital or other organization not exempt employs as many as eight persons, that physician or organization is liable for additional taxes. The simplest way is to determine one's status as an employer or as an employee and set one's course right so that one will not be called on later to pay taxes and accrued penalties.—Wm. C. Woodward, M.D., L.L.M., Chicago.

\* \* \*

*Death in Florida.*—In 1935, Dr. Hendry Connell of Kingston, Ont., announced the discovery of "Ensol" for use in treating cancer. The press hailed it as a new "cancer cure," but the American Medical Association condemned the fluid as unscientifically compounded. Dr. Morris Fishbein, A.M.A. spokesman, editorialized: "Public officials, university officials, and some Canadian physicians have been led into participation in the promotion of a project which will inevitably bring them grief."

At Orlando, Fla., last week grief came not to officials but to ten cancer patients—two men, eight women—who died from a lockjaw-like disease. Four others lay seriously ill in local hospitals. All had been given injections of "Rex" (name of a drug made under the Ensol formula by the Biochemical Research Foundation, Philadelphia).

Last fall, when Elixir of Sulfanilamide killed ninety-three persons throughout the country, government agents had to trace more than 1,000 shipments to warn doctors of danger (*News Week*, Nov. 1, 1937). In tracking down Ensol shipments, the Federal Food and Drug Administration found that only six physicians in New York, Ohio, Kansas, Michigan, and Wisconsin possessed the drug—and they had just fifty-four vials of Ensol among them. It took but a few hours to telephone them to hold their supplies for future examination.

In Kingston, Dr. Connell defended himself: "I

JOUR. M.S.M.S.

am convinced one bottle of Ensol became contaminated." But health officials took two vials at random from the supply of Dr. T. A. Neal—who had administered the drug to Orlando victims—and injected the contents into guinea pigs. Since some of the animals died of lockjaw, it is believed Dr. Neal's entire stock was contaminated.—*News Week*, April 11, 1938.

\* \* \*

### School Health Educational Institute

The Division of Hygiene and Public Health and the Extension Service of the University of Michigan in coöperation with the Michigan School Health Association announce a School Health Education Institute, May 27 and 28, 1938, at the Michigan Union, University of Michigan, Ann Arbor.

#### PROGRAM

Friday, May 27

#### Morning

*Bernard W. Carey, M.D., President of the Michigan School Health Association, presiding*

#### REGISTRATION.

INTRODUCTORY REMARKS. Bernard W. Carey, M.D.

TRENDS IN SCHOOL HEALTH EDUCATION. John Sundwall, M.D., President of the American School Health Association, and Director of the Division of Hygiene and Public Health, University of Michigan.

INTERMISSION. (Discussion.)

SOME DEBATABLE ISSUES IN HEALTH EDUCATION. J. B. Edmonson, Ph.D., Dean, School of Education, University of Michigan.

INTERMISSION. (Discussion.)

SEEKERS OF HEALTH. Thurman B. Rice, M.D., Chief, Bureau of Health and Physical Education, Indiana Division of Public Health.

LUNCHEON, 60c.

BUSINESS MEETING, Michigan School Health Association.

#### Afternoon

*J. D. Brook, M.D., Member of Board of Directors, Michigan School Health Association, presiding.*

THE MEDICAL PROFESSION AND THE PUBLIC SCHOOLS. Henry Cook, M.D., President, Michigan State Medical Society.

INTERMISSION. (Discussion.)

THE STATE DEPARTMENT OF PUBLIC INSTRUCTION AND HEALTH EDUCATION. Hon. Eugene B. Elliot, Superintendent of Public Instruction.

INTERMISSION. (Discussion.)

THE STATE DEPARTMENT OF HEALTH AND HEALTH EDUCATION. Don W. Gudakunst, M.D., State Health Commissioner.

INTERMISSION. (Discussion.)

COLLEGE HEALTH PROGRAMS IN MICHIGAN. THEIR PRESENT STATUS. Glenadine Snow, M.D., Director, Student Health Service, Ypsilanti State Normal College.

INTERMISSION. (Discussion.)

DINNER, 75c (Michigan Union).

Kenneth L. Heaton, Ph.D., Director, Bureau of Curriculum Research, Lansing, Toastmaster.

THE MICHIGAN SCHOOL HEALTH ASSOCIATION. WHAT IT STANDS FOR. Bernard W. Carey, M.D., President, Michigan School Health Association.

THE AMERICAN SCHOOL HEALTH ASSOCIATION. John Sundwall, M.D., President, American School Health Association.

THE UNIVERSITY AND SCHOOL HEALTH EDUCATION. James D. Bruce, M.D., Director, Division of Health Sciences, University of Michigan.

MEETING OF CITY AND COUNTY HEALTH OFFICERS. Sue H. Thompson, M.D., Director, Health District No. 2, West Branch, Michigan, Presiding.

ADDRESS: Don W. Gudakunst, M.D., State Health Commissioner.

Saturday, May 28

#### Morning

*V. K. Volk, M.D., Secretary, The Michigan School Health Association, presiding.*

THE PHYSIOLOGICAL BASIS OF HEALTH. John W. Bean, M.D., Assistant Professor of Physiology, University of Michigan.

INTERMISSION. (Discussion.)

HEALTH MISCONCEPTIONS. Warren E. Forsythe, M.D., Director, University Health Service, University of Michigan.

INTERMISSION. (Discussion.)

COORDINATION OF HEALTH AND PHYSICAL EDUCATION. Thurman B. Rice, M.D., Chief, Bureau of Health and Physical Education, Indiana Division of Public Health.

LUNCHEON, 60c.

May, 1938

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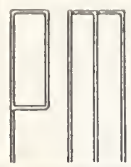
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### Afternoon

Louise Knapp, R.N., Professor of Public Health Nursing, Wayne University, Detroit, presiding.

THE NURSE'S CONTRIBUTION TO SCHOOL HEALTH EDUCATION. Grace Ross, R.N., Supervisor of Nursing, Detroit Department of Health.

INTERMISSION. (Discussion.)

THE PROBLEM SOLVING APPROACH TO SCHOOL HEALTH PROBLEMS. Mabel E. Rugen, Ph.D., Associate-Professor of Physical Education, University of Michigan.

INTERMISSION. (Discussion.)

A SIX-POINT PROGRAM FOR THE IMPROVEMENT OF DENTAL HEALTH. (Illustration.) Kenneth A. Easlick, D.D.S., Assistant-Professor, School of Dentistry, University of Michigan.

INTERMISSION. (Discussion.)

CHILD GUIDANCE IN THE PUBLIC SCHOOLS. Paul H. Jordan, M.D., Psychiatrist, Michigan Child Guidance Institute, Ann Arbor.

DISCUSSION.

\* \* \*

## EXHIBITORS AT 1938 MICHIGAN STATE MEDICAL SOCIETY CONVENTION

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Van Hoosen Farm.....	Rochester, Mich.	37
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## CREDIT IS DUE

The following members of the Michigan State Medical Society were present at the postgraduate assemblies of the M.S.M.S. Annual Meeting in Grand Rapids, September, 1937. This list represents the registration of Thursday, September 30 (the final day of the convention):

Drs. U. M. Adams, Marcellus; J. H. Ahronheim, Jackson; Herman Albrecht, Detroit; R. W. Albi, Lake City; Norman M. Allen, Detroit; H. R. Allen, Battle Creek.

Drs. Helen S. Barnard, Muskegon; W. H. Barnum, Fremont; Perry C. Beck, Bronson; Frederick M. Boothby, Lawrence; Earl W. Brubaker, Lansing; G. R. Bullen, Jackson.

Drs. Carl D. Camp, Ann Arbor; James B. Campbell, Big Rapids; Clinton C. Collier, Whitehall; W. B. Cooksey, Detroit.

Drs. Russell N. DeJong, Ann Arbor; H. J. Damstra, Wayland; A. R. Dickson, Battle Creek.

Dr. Clarence H. Eisman, Detroit.

Drs. D. L. Finch, Augusta; L. C. Ferrand, Rockford; C. B. Fleischman, Muskegon; Earl H. Foust, Lansing; F. Bruce Fralick, Ann Arbor.

Drs. Harold H. Gay, Saginaw; R. E. Goldner, Lansing; Martha H. Goltz, Montague; Wm. S. Gonne, Detroit; George P. Graybiel, Caledonia; Harry Greenbaum, Jackson.

Drs. Thomas Hackett, Jackson; J. F. Harrold, Lansing; Geo. A. Harrop, Baltimore; Harold Henderson, Detroit; E. J. Hernes, Lansing; Wm. G. Hoebeke, Kalamazoo; Marinus Hoffs, Lake Odessa; J. J. Holes, Battle Creek; D. James Houston, Swartz Creek; J. W. Hoverter, Evart; T. W. K. Hume, Auburn Heights; Arthur A. Humphrey, Battle Creek; W. B. Huntley, Jackson; M. S. Hurth, Lansing.

Dr. Francis A. Jones, Lansing.

Drs. Wm. J. Klerk, Kalamazoo; John F. Konopa, Manistee; Earl E. Kleinschmidt, Ann Arbor; Christian Krupp, Grand Rapids.

Drs. E. O. Leahy, Jackson; Cecil W. Lepard, Detroit; D. Lettinga, Grant; G. W. Logan, Flushing.

Drs. R. R. McCrumb, Lansing; W. E. McNamara, Lansing; A. W. Mulligan, Muskegon.

Drs. L. C. Nelson, Bronson; R. E. Newton, Jackson; Wm. W. Norris, Portland.

Dr. C. Oden, Muskegon.

Drs. Chas. H. Peabody, Lake Odessa; E. Madison Paine, Sr., Grand Ledge; E. M. Paine, Grand Ledge; C. W. Perry, Kalamazoo; W. L. Peters, Morenci; R. A. Pinkham, Lansing; F. A. Pratt, Kalamazoo.

Drs. Clara V. Radabaugh, Battle Creek; Henry K. Ransom, Ann Arbor; C. J. Richards, Durand; Wendell H. Rooks, Pontiac.

Drs. G. P. Sackrider, Owosso; G. T. Soule, Henderson; Wilbur F. Stewart, Flint; Howard T. Stuch, Allegan.

Drs. Charles Ten Houten, Paw Paw; K. W. Toothaker, Lansing.

Drs. W. R. Vaughan, Plainwell; John C. Volderauer, Kalamazoo.

Drs. R. W. Waggoner, Ann Arbor; P. V. Waghy, Pontiac; D. R. Wark, Flint; R. R. Whitten, Ionia; F. N. Williams, Hartford.

Dr. N. Del Zingro, Goodrich.

## Among Our Contributors

Dr. Fred P. Currier was graduated from the University of Michigan, with the degrees of B.S. and M.D. He was formerly an instructor in internal medicine and neurology at the University of Michigan. Dr. Currier took post-graduate work in the National Hospital, London, England, for one year. He has limited his practice to neurology since 1922, and is a member of the consulting staff of Blodgett and Saint Mary's Hospitals, Grand Rapids, Michigan.

\* \* \*

Dr. Haven Emerson was graduated A.B. from Harvard in 1896, A.M. from Columbia in 1899, and from the College of Physicians and Surgeons in 1899. Dr. Emerson was formerly Health Commissioner of New York City. He has been Professor of Public Health Practice at the College of Physicians and Surgeons of Columbia University since 1921. He was president of the American Public Health Association in 1934. Dr. Emerson is a member of the Committee of Expert Statisticians of the Health Section of the League of Nations.

\* \* \*

Dr. George A. Harrop was graduated from Harvard with the degree of A.B. in 1912, and M.D. from Johns Hopkins University in 1916. He was Associate Professor of Medicine in charge of Metabolic and Endocrine Research at Johns Hopkins University Hospital from 1923 to 1937. Dr. Harrop has been Director of Research for E. R. Squibb & Sons, New Brunswick, New Jersey, since 1937, and Lecturer in Biology at Princeton University since 1937.

\* \* \*

Dr. G. Warren Hyde is a graduate of the University of Michigan Medical School, 1925, and served his internship at Harper Hospital, Detroit, 1925-1926. He took postgraduate training in dermatology and syphilology with Dr. Earl D. Osborne, University of Buffalo, Buffalo, New York, 1926-1928. He is a member of the Detroit Dermatological Society (president-elect), Central State Dermatological Association, American Academy of Dermatology and Syphilology, Wayne County Medical Society, Michigan State Medical Society and American Medical Association.

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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

A TEXT-BOOK OF PATHOLOGY, Edited by E. T. Bell, M.D., Professor of Pathology, University of Minnesota, Minneapolis, Minnesota. Contributors: E. T. Bell, M.D., Professor of Pathology, B. J. Clawson, Professor of Pathology, Hal Downey, Ph.D., Professor of Hematology, J. S. McCartney, M.D., Associate Professor of Pathology, and C. J. Watson, M.D., Associate Professor of Medicine, University of Minnesota, Minneapolis, Minn. Third edition, enlarged and thoroughly revised, published 1938. Octavo, 894 pages, illustrated with 412 engravings and 2 colored plates. Cloth, \$9.50, net. Washington Square, Philadelphia: Lea & Febiger.

The third revision of this work has made it possible to bring it abreast with current medical thought on the subject. The book has been increased in size by over one hundred pages and sixty-two new illustrations have been added. The plan of the work is such that the student is able to approach clinical medicine as a direct continuation of his work in pathology. In other words, clinical medicine will not be found a new and different field. The arrangement of the work is such that it resembles a text on the practice of medicine, except that the emphasis is on pathology rather than etiology and symptomatology. It will make a splendid companion book to any work on practice.

THE PRINCIPLES OF ROENTGENOLOGICAL INTERPRETATION. By L. R. Sante, M.D., Professor of Radiology, St. Louis University School of Medicine, Radiologist to St. Louis City Hospital and St. Mary's Hospital, St. Louis. 340 pages, illustrated. Price \$5.50. Ann Arbor: Edwards Brothers, Inc., 1938.

This is a very teachable work. Instead of reproductions of roentgenograms, which are sometimes confusing to students and beginners, the illustrations are largely line drawings from x-ray films. This has enabled the author to emphasize the pathology under discussion and to bring it into relief. Though a splendid way of enlightening the student or the physician striving to obtain an intelligent conception of the subject, the radiograph should also be studied. It cannot be dispensed with. The whole range of roentgenography is presented. One hundred and eleven pages are devoted to fractures and bone disease. The various systems of the body are adequately discussed from the roentgenographic viewpoint. A commendable feature is the list of questions appended to each chapter for self-examination. The author is recognized by roentgenologists everywhere as one of the most competent to write such a text-book. A unique feature is the format in which the work appears. The pages are large, 8 by 11 inches in size, with double columns printed in typewritten style and photolithographed. Unusual as this method of bookmaking is, the effect on the whole is pleasing as it makes for easy reading.

BOOK OF TYPEFACES AND EDITORIAL HELPS. Limited edition. Copies on request. The Bruce Publishing Company, St. Paul, Minnesota.

This work discusses the subject of type in all its phases. It should interest all readers as well as editors. The selection of type is an art in itself. The printed page increases in interest the more we know about its mechanics. The point system is described at length, as well as the great variety of letters, by illustration. The question, what is a half-tone, is clearly explained. For the authors of papers, all the commonly used proofreader's correction marks are given.

# THE JOURNAL

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No. 6

## THE CONTRAST BETWEEN THE TREATMENT OF HEART FAILURE AND PERIPHERAL CIRCULATORY FAILURE\*

ALVAN L. BARACH, M.D.

NEW YORK CITY



In the course of many clinical illnesses, the circulation abruptly fails. A rapid pulse of small volume and low tension is then generally present. The physiological mechanism which is causative of the condition varies widely; in some cases cardiac insufficiency is responsible, in others the function of the peripheral circulation is significantly disturbed. Since the treatment of these conditions involves procedures which are diametrically opposed to each other, it is important to determine whether circulatory failure has resulted from a defective working of the heart or the peripheral blood vessels.

Heart failure may be due to a damaged heart muscle, to valvular disease or to external influences affecting the heart, such as pericarditis. The left side of the heart is more commonly involved. Thus, arteriosclerotic disease of the coronary arteries, syphilitic aortitis, hypertension, and defects of the aortic and mitral valves are frequent causes of left ventricular failure. After a variable period of time, right ventricular failure may add itself to failure of the left ventricle. Both ventricles may become affected at the same time, as by rheumatic fever or generalized arteriosclerosis. Isolated failure of the right heart is less common, occurring in those conditions in which there is a resistance to the flow of blood through the pulmonary blood vessels, such as emphysema, fibrosis of the lungs, thoracic deformities and certain rare diseases of the pulmonic and tricuspid valves, and arteries.

In long-standing left ventricular failure, the increased congestion and pressure of blood in the pulmonary circulation also imposes an additional burden on the right heart.

Left ventricular failure may also occur suddenly in patients with pre-existing compensated heart disease accompanied by marked dyspnea (cardiac asthma), or pulmonary edema. Acute isolated failure of the right ventricle takes place rarely and then only under special circumstances, such as pulmonary embolism. The characteristic disturbance in the pathological physiology of failure of either side of the heart is an accumulation of blood in the peripheral circulation. If the left ventricle is failing, blood backs up in the pulmonary veins and the lungs. The conspicuous symptoms of this condition are dyspnea and cough. When the right ventricle becomes insufficient, blood is dammed back into the inferior and superior cavæ and their tributaries. The peripheral organs, such as the liver and the

\*From the Department of Medicine, Columbia College of Physicians and Surgeons and the Presbyterian Hospital, New York. Read before the Michigan State Medical Society, September 28, 1937.



spleen, are enlarged because of the increased quantity of blood which they have acquired. Edema of the extremities results as the blood vessels carry blood under an increased pressure. Measurement of the venous pressure in the arm veins reveals whether the right ventricle is adequately emptying itself. It does not, however, give information as to the function of the left ventricle. The presence of pulmonary congestion may be clinically recognized and ascribed to left ventricular failure. In the majority of instances of congestive failure there is a slowing of the circulation velocity, determined by the time it takes for a sensation of taste to be aroused when a suitable substance, such as decholin or saccharin, is injected into an arm vein of the patient. Thus, the arm to tongue circulation time may be prolonged from a normal range of fifteen to twenty seconds to thirty to fifty seconds.

In left ventricular failure, there is generally a lowered arterial oxygen saturation and a decrease in the vital capacity of the lungs due to congestion of blood in the lungs. Since the cause of isolated right ventricular failure is usually pulmonary disease, the arterial oxygen saturation and the vital capacity are here, too, frequently found to be lowered below the normal range.

#### Dilatation of the Heart

Heart failure is almost always accompanied by dilatation of the heart. In some cases, an increased resistance in the aorta is responsible; in other cases, a relatively greater venous inflow to the heart is the occasion for increased work, which in the damaged heart initiates dilatation. The poorly functioning ventricle fails to empty itself as completely as it formerly did. The residual blood in the ventricle increases progressively since the venous inflow may remain constant during diastole. However, a point is reached after the cardiac volume has increased in which output equals inflow. This new state of affairs is accompanied by a decreased efficiency. The oxygen consumption of the dilated heart is greater for a comparable amount of work than the normal heart. Starling's law of the heart may be mentioned: "Within limits the larger the volume of the heart the greater are the energy of its contraction and the amount of chemical change at each contraction."

#### Peripheral Circulatory Failure

If we now consider that type of circulatory failure known as peripheral circulatory failure, we are at once struck by an opposite state of physiological affairs in the body. The heart is not dilated. Instead of an overfilling of the circulation, either pulmonary or systemic, there is an underfilling of the vascular bed. The primary disturbance is in fact a diminution of the amount of blood returning to the auricles. The cause of the deficient venous return is significantly related to a decrease in circulating blood volume.

Clinically, there is an absence of orthopnea, cough and edema. The patient is characteristically pale, the skin cold and clammy. The superficial veins are collapsed. The venous pressure is generally very low. The arterial blood pressure, although it may not be affected as an early manifestation, is unusually low in most instances. The oxygen content of the venous blood is greatly lowered. In severe experimental shock, the oxygen consumption is markedly decreased.<sup>1</sup>

This syndrome, peripheral circulatory failure, was commonly recognized as the clinical manifestation of surgical shock, occurring frequently after injuries, operations and hemorrhage. Its importance in non-surgical illness led Atchley to call attention to the condition under the name of "medical shock."<sup>2</sup> He pointed out that Janeway<sup>20</sup> had emphasized that circulatory failure was often ascribed to heart failure when in reality impaired functioning of the peripheral vascular bed was the seat of the trouble. In the course of infectious disease, such as pneumonia, in infarction of the coronary or pulmonary arteries, in Addison's disease, diabetic acidosis, and in other conditions, peripheral circulatory failure frequently takes place.

The nature of this disturbance has been subjected to intensive study, and we do not feel obliged nor indeed capable of presenting a clear picture of what takes place. Our purpose is to present those physiological data that provide an intelligent basis for treatment. Most important is the realization that the volume of blood in active circulation is decreased, and that the blood volume returns to normal as the clinical condition of the patient improves.<sup>21</sup> The decreased blood volume is responsible for the heart acquiring and delivering a smaller quantity

of blood. The lowered blood flow results in severe tissue anoxemia.

The cause of the decreased blood volume is undoubtedly a variable one. In severe hemorrhage, and in injuries where there is considerable extravasation of blood,<sup>10</sup> loss of plasma can be accounted for. In other conditions, such as shock in pneumonia, coronary thrombosis, blows on the testicle, the physiologic mechanism has not been made clear. Shock does not appear to be due to failure of the vasomotor center with dilatation of the arterioles, since the pale skin as well as pale viscera and peritoneum indicate that the arterioles are not relaxed.<sup>11</sup> The theory that traumatized tissue gives off a toxic shock-producing substance still remains to be proved. Although histamine initiates shock,<sup>12</sup> the condition is not comparable to clinical shock since in the former capillary dilatation does take place with stagnation of red blood cells and passage of plasma into the tissue spaces. Failure of the veno-pressor mechanism has been advanced as a cause of shock<sup>15, 16, 17, 18, 19</sup> but this explanation has not been accepted. The essential concept is the diminished blood volume and its consequences. Just where the blood, both plasma and cells, which has been lost from the active circulation, can be found is still a mystery.

With such a varying pathogenesis, the treatment of peripheral circulatory failure and heart failure is radically different. The restoration of the blood volume to or near the normal level is aimed at when the diagnosis of shock can be made. The intravenous injection of 50 per cent glucose or sucrose, in approximately 100 c.c. amounts, followed by intravenous injection of 1,000 c.c. of normal saline or 5 per cent glucose are customary measures. Hypertonic salt solutions may also be employed. If repeated injections of salt and glucose are not efficacious, transfusions should be employed. These intravenous treatments should be continued until the arterial pressure is elevated to a satisfactory level or the clinical condition of the patient shows distinct improvement. Medication is of secondary importance; nevertheless, there is good reason to administer stimulants such as caffeine sodium benzoate and particularly metrazol in full doses. The administration of oxygen in concentrations above 50 per cent is always indicated. For twelve hours of the twenty-four it is safe to give 90 to 100 per cent

oxygen, and this dosage should be employed whenever it is practicable to do so in severe shock. In a carefully studied case of peripheral circulatory failure treated in an oxygen tent, the blood flow through the hands showed a marked fall when the oxygen concentration was lowered from 50 per cent to 21 per cent.<sup>14</sup>

The treatment of heart failure depends to a large extent on the type and severity of the presenting condition. We do not intend to review the routine treatment of heart disease but to point out the essential differences between its treatment and that of peripheral circulatory failure. In severe congestive failure, phlebotomy or tourniqueting the extremities is at times of dramatic value in removing some of the burden of a dilated and tired heart. The increased efficiency of the cardiac muscle, due to decreasing the amount of blood in active circulation, may be followed by a better state of the circulation, with improved breathing, lessening of pulmonary congestion and at times clearance of pulmonary edema. Limiting the administration of fluids is an outstanding indication. A more recent treatment is positive pressure respiration. In this procedure the patient breathes under a pressure of 5 to 8 cm. of water, either in a hood or through a mouthpiece.<sup>5</sup> The increased pressure within the chest hinders the entrance of blood into the right heart. In addition, the positive pressure within the lung exerts a direct opposing pressure on the walls of the pulmonary capillaries, which tends to stop oozing of serum. Pulmonary edema has been successfully treated in animals with this method,<sup>13</sup> and cardiac asthma (paroxysmal cardiac dyspnea)<sup>23</sup> and pulmonary edema<sup>8</sup> in human beings.

The therapeutic use of oxygen in heart failure is of special importance in congestive heart failure, especially in arteriosclerotic heart disease.<sup>3, 4, 6, 7, 9, 22, 24</sup> The heart muscle is especially sensitive to oxygen-want and in most cases of congestive heart failure there is a lessened tension of oxygen in the arterial blood and, therefore, in the cardiac muscle. The administration over prolonged periods of 50 per cent oxygen may result in restoration of compensation even when other methods have not been successful. As the breathing becomes less difficult, there is a fall in pulmonary ventilation. After oxygen has been continued for three to six days a diuresis takes



place in some cases. At this time, the  $\text{CO}_2$  content of the arterial blood has become elevated from approximately 45 volumes per cent to 65 to 75 volumes per cent, the H-ion concentration remaining at this time within normal limits. The high tension of  $\text{CO}_2$  permits a greater elimination of carbon dioxide per breath and thus allows the patient to take advantage of the lower pulmonary ventilation which inhalation of a high oxygen atmosphere accomplishes. The diuresis may be due to improved action of the heart muscle in a high oxygen atmosphere. The latent interval which is present before it begins has not yet been satisfactorily explained.

### Summary

We have attempted to focus attention on the importance of determining in a given case of circulatory failure whether the failure of the heart is responsible or whether the peripheral vascular bed is at fault. When the ventricles become insufficient there is an overfilling of the circulation, and congestion of the lungs or the viscera or both take place. In addition to routine measures, removal of blood from the active circulation may be helpful in relieving the burden on the heart. Phlebotomy, tourniqueting the extremities or positive pressure respiration have been employed under these circumstances. In peripheral circulatory failure, the lowered blood volume is responsible for the diminished entrance of blood into the heart and the secondary signs of circulatory failure. Restoration of a more adequate blood volume is then indicated by intravenous injection of hypertonic glucose, sucrose and saline solutions. Transfusions or repeated injections of normal salt solution are also used. In both situations tissue

anoxemia exists and should be treated by effective administration of oxygen.

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## PULMONARY COMPLICATIONS IN ADULT MEDICAL AND SURGICAL PATIENTS\*

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We purpose to discuss the pulmonary complications occurring in persons seriously ill with surgical and non-surgical diseases. Recently a physician of ripe clinical experience and scholarly attainments who was engaged in an historical survey of a topic in medicine remarked that he was more than ever impressed with the old statement that there is relatively little new in clinical medicine, and that many of the apparently new developments in medicine were clearly described insofar as was possible by the limitations of knowledge of the fundamental sciences, fifty or a hundred years ago.

The material presented here contains no new facts, but we hope to draw together old, well-recognized observations through the medium of necropsies, so that the relative incidence of the several types of pulmonary complications, their relations to each other, and their importance to the patient, may be evident. Errors of omission and of commission in clinical diagnosis frequently originate in failure to bear in mind the common probabilities. A review of these probabilities will be of service in distinguishing between conditions which frequently produce similar physical signs.

These observations are based on 845 consecutive necropsies in the Presbyterian Hospital, Chicago, 1929-1936, on patients over twelve years of age. Cases in which permission was obtained for partial necropsy only, are omitted. The percentage of necropsies in the hospital during the period under study was between 50 per cent and 60 per cent, and the results of necropsies made are believed to be representative of the conditions which would have been found had necropsies been obtained in all deaths.

The problem may be indicated by examples of common clinical situations. Following an operation by a few days a patient has sudden pain in the side of the chest, cough, expectoration of bloody sputum, fever, and accelerated respiration. Post-operative lobar pneumonia is thought of, but pulmonary embolism with infarction is much more probable. Again a patient has accession of fever, perhaps cough, and physical signs of râles in lungs, perhaps dulness and varying degrees of alteration of breath

sounds. A diagnosis of bronchopneumonia of upper respiratory tract origin, usually made, may be correct, but more often the condition will be found to be due to other causes which include aspiration pneumonia from aspiration of stomach contents, infarcts possibly septic with secondary pulmonary abscesses, and compression atelectasis resulting from collections of fluid or pus in the pleura, or from pressure from distended abdomen, associated with peritonitis. Of 662 necropsies showing significant pulmonary disease, bronchopneumonia of upper respiratory tract origin, as indicated by pathologic changes in the lungs, and cultures to be described later, was found in 122 instances. In the remaining 540 cases, pulmonary disease other than bronchopneumonia of the ordinary type was present. The routine diagnosis of bronchopneumonia in these cases would be more often wrong than right in the proportion of over four to one. It may be argued that these were fatal cases anyway, and that the exact pulmonary diagnosis was, therefore, of academic interest only. But aside from the desire to strive for more accurate interpretation of symptoms and physical signs, which means, in the end, progress in medicine, the distinction between types of pulmonary complications has more than academic interest, notably in prognosis when the clinical interpretation is made during the course of the illness, and also therapeutically in that some of these conditions are in part preventable (aspiration pneumonia).

The principal complications found (Table I) were edema and passive congestion (110), pulmonary infarction and embolism

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TABLE 1. PRINCIPAL PULMONARY COMPLICATIONS IN 845 NECROPSIES

	1929	1930	1931	1932	1933	1934	1935	1936	Total
Edema and Passive Congestion	24	13	12	11	11	16	12	11	110
Infarction, Pulmonary Embolism	6	13	12	15	10	8	11	13	88
Septic Infarcts	3	8	6	8	3	5	5	5	43
Compression Atelectasis	7	6	5	1	2	5	0	2	28
Bronchopneumonia	18	17	13	13	14	18	16	13	122
Aspiration Pneumonia	23	29	22	20	15	15	20	27	171
No Pulmonary Complications	16	24	25	16	15	30	28	29	183
TOTAL NECROPSIES	110	117	104	95	80	113	106	120	

(eighty-eight), septic infarcts (forty-three), atelectasis from compression of lung by fluid, or by abdominal distension (twenty-eight), bronchopneumonia, respiratory type (122), aspiration bronchopneumonia from aspiration of stomach contents (171). Other pulmonary lesions occurring less frequently included thrombosis of pulmonary artery (fourteen), lobar pneumonia either primary or occurring later in an illness (thirteen), pulmonary tuberculosis (eleven), tumors of the lung primary or metastatic (twenty-one). It will be noted that the distribution of the principal complications is fairly uniform in the several years, and it is believed that a more extensive survey now in progress will not greatly modify the figures of their relative incidence.

#### Pulmonary Embolism and Infarction

References to pulmonary embolism usually first call to mind sudden, tragic deaths in persons apparently convalescent from operations, and much has been written concerning the causes of unrecognized thrombi in the large veins of the lower trunk. The admitted causes are low grade infection, stasis, alteration of clotting factors, and mechanical injury, leading to formation of slightly adherent, easily displaced clots in large veins which suddenly occlude the pulmonary artery with resultant death. This type of large emboli with sudden death, of which there were some ten instances, constitute but a small proportion of total incidence of pulmonary embolism and infarction. In 845 necropsies, in 662 of which there were significant lesions of the lung, there were 131 instances of embolism (15 per cent of all necropsies, and 20 per cent of all pulmonary lesions). It should, of

course, at once be noted that in many cases the embolic lesions were not the cause of death and appeared as incidental findings along with the more grave primary cause of death. Many were, no doubt, symptomless, and from their position and size could hardly have produced physical signs permitting their diagnosis. Others, however, caused symptoms and physical signs which were variously interpreted in the clinic. This unexpectedly large incidence of pulmonary embolism by medium sized and small emboli is of interest clinically. Moderate sized emboli lodge in the smaller branches of the pulmonary artery with resulting hemorrhagic consolidation of a portion of the lung, and frequently pleurisy. This occurrence is manifested clinically by sudden pain, often bloody expectoration, and fever varying with the extent and course of the infarct. It is often mistakenly diagnosed as lobar pneumonia. Physical signs, in addition to the friction rub present, are those of consolidation. The x-ray film may show the increased density often of the characteristic wedge shape. The infarcted region may resolve, or abscess, or gangrene may result. This form of pulmonary infarct is not rare, and is often easily recognizable if the possibility of its occurrence is kept in mind.

Small emboli produce fewer symptoms, and may pass unnoticed. Sometimes when they lie at the periphery of the lung pleurisy of short duration occurs. Hemoptysis is rare. There may be slight fever. Occasionally, by reason of their large number, the effect of extensive consolidation of the lung is produced, as occurs in some cases of chronic heart disease with multiple mural thrombi. The number of non-fatal instances

of small pulmonary infarcts, some only of which produce recognizable symptoms, must be large.

TABLE II. PULMONARY EMBOLISM AND INFARCTION

(Principal Associated Lesions)

*Simple Infarct*

Simple Venous Thrombosis.....	32
Heart Lesion .....	36
Thrombosis with Evident Infection.....	7
Abdominal Operation with Peritonitis.....	4
Pelvic Operations, Prostate, etc.....	5
Others .....	4

*Septic Infarcts*

Clearly Evident Infection.....	30
Presumably Infectious .....	8
Simple Thrombosis .....	5

The source of the emboli, and the nature of the preceding thrombosis, whether simple or infected, is of some assistance in diagnosis, and in the prognosis of recognized infarcts (Table II). Of eighty-eight instances of simple infarcts, thirty-six originated from intracardiac thromboses, consecutive to valvular or myocardial disease. Here the pulmonary lesion was usually a final or contributing factor in an otherwise inevitably fatal outcome. In thirty-two of thirty-nine other simple infarcts the preceding venous thrombosis was not obviously infected, while in only seven was the thrombosis in an infected field. On the other hand, of forty-three septic infarcts, thirty were clinically associated with suppurative involving veins, and in only five was the thrombosis apparently simple. When, therefore, pulmonary infarcts occur in patients with frankly suppurative processes, the probability is great that these infarcts will be septic with subsequent possible pulmonary abscess or empyema, and in any case a serious prognosis.

In addition to these cases of pulmonary embolism and infarction, there were twelve instances of thrombosis of the pulmonary artery without infarction. These occurred often as a terminal event, usually associated with thrombosis in other vessels, or associated with infectious processes. Carnification of the lung with retrograde thrombosis of the pulmonary arteries was found in two instances.

### Aspiration Bronchopneumonia

The alterations in the respiratory tract which result from the aspiration of contents of the stomach into the bronchial tree have been recently described by one of us (C. W. A.). One of the earliest descriptions of

this condition was by Ernst Becker, in 1886. Later Woillez, in France, described the same condition and Balfour referred to the danger of aspiration of stomach contents in discussing postoperative complications.

Grossly, on section the lungs are overdistended and do not collapse on removal of the sternum. Material similar to that found in the gastrointestinal tract may be found in the trachea, and also in the smaller bronchi—even to the periphery of the lung. The extent of the bronchial changes will depend on the amount of aspirated material and on the duration of life after the material entered the lungs. Occasionally the amount of material aspirated is large and death occurs by acute asphyxiation. Death may occur after the aspiration of smaller amounts, in persons already weakened by disease. If the patient survives for a few hours or days, the bronchial lining is found intensely red from engorgement of capillaries and the mucous membrane is desquamated. The lung tissue is boggy, with hyperemia, edema and hemorrhage. The description conforms to that referred to as acute pneumonitis in literature on postoperative complications. The blood in the lung is dark, almost black, and by reason of early hemolysis, the tissues of the pleura, lung and mediastinum are tinged red.

Histologically the lung tissue shows edema, hemorrhage and necrosis of alveolar walls. Bronchioles may contain plugs of foreign materials.

Cultures from the lung and from the gastro-intestinal tract, show the same organisms, most commonly colon bacilli, staphylococci, Gram-positive rods and streptococci.

Experimentally, the lung changes of aspiration pneumonia have been produced in dogs by Apfelbach and Christianson, by the instillation in the trachea of material from a dilated stomach.

In general this form of bronchopneumonia is most easily recognized in bodies examined soon after death. It is distinguished from ordinary bronchopneumonia by the early hemolysis in fresh bodies, by edema, hemorrhage and desquamation in the alveolar tissues, possibly the persistence of foreign material in the trachea and bronchi, and is confirmed by the finding in cultures of organisms similar to those in the gastrointestinal tract.



Ordinary bronchopneumonia is usually assumed to result from aspiration of infected mucus from the pharynx. Cultures frequently show pneumococci and streptococci. It is possible that even bronchopneumonia of the ordinary type, in which sometimes colon bacilli and other organisms usually associated with gastrointestinal tract are found, may be due in part to aspiration of regurgitated stomach contents.

In patients, in whom at necropsy aspiration pneumonia is found, the ante-mortem diagnosis has been frequently acute dilatation of the heart, cardio-vascular collapse, pulmonary embolism, coronary thrombosis and bronchopneumonia. Such diagnoses are evidently clinical attempts to account for sudden and unexpected changes in patients' condition. Frequently this form of pneumonia is only the terminal event in patients who would shortly die of other diseases, but in a considerable number it is a major complication, which, in some instances at least, might have been avoided.

A review of the associated pathology suggests some of the more obvious causes leading to aspiration pneumonia. Of the 171 recognized instances, in fifty-five there was dilatation of the stomach, or obstruction or infarction of the bowel, conditions frequently leading to eructations and vomiting. Aspiration pneumonia is frequently associated with operations on stomach and biliary tract. In twenty-one other instances there was peritonitis. In another group of twenty-two, conditions such as cerebral thrombosis or tumor, uremia, meningitis, and coma which obviously lead to abolition of protective reflexes were present.

A recent study of progress notes and nurses' records of patients in whom aspiration pneumonia was found, showed that hiccup, retching and nausea were more common than vomiting. In one patient, with brain tumor, who was continuously and uninterruptedly watched during his postoperative course, there were slight diaphragmatic contractions, but no vomiting whatever, yet at necropsy extensive and typical aspiration pneumonia was found.

It is believed that the postoperative use of continuous aspiration of the stomach has reduced the incidence of this form of pneumonia.

Another group which contributes a rather high incidence of aspiration pneumonia (twenty-two) is that of operation on the

prostate and bladder. These patients are usually advanced in age and often in other respects poor surgical risks. In such patients ileus is not infrequent.

Recently in some clinics, there has been an extensive use of non-volatile anesthetics of the barbitol group in which the protective reflexes remain depressed for a number of hours following operations and the question is raised whether such anesthetics may tend to increase the number of early post-operative aspiration pneumonias. This question cannot be answered in this study because of the very limited use of non-volatile anesthetics in the Presbyterian Hospital.

### Edema and Passive Congestion

Of eighty-eight instances in which edema and passive congestion of the lungs was pronounced, the associated pathologic findings concerned the heart in fifty-six cases, and in eleven others the principal finding was high grade anemia, usually from acute hemorrhage. Of the cardiac lesions thirty-five were myocardial, with coronary obstruction and infarction leading the list, and twenty-one were valvular lesions. In most of the remaining cases, other lesions causing death were such as might indirectly lead to circulatory impairment.

### Compression Atelectasis

Atelectasis by compression of the lung without other significant change was found in twenty-eight instances.

In twenty-three, accumulations of fluid in the pleura caused chiefly by metastatic tumors and by cardiac lesions compressed the lung, while in five the pressure was produced by upward displacement of the diaphragm by the distention of peritonitis or ascites.

### Bronchopneumonia

Ordinary bronchopneumonia was only a contributing cause of death in almost all cases in which it was found at necropsy. In a summary of the associated pathologic findings no special type of lesion stands out as is the case in pulmonary embolism. In general, the pathologic findings were such as would cause weakness, general depression of resistance and not infrequently suppression of normal reflexes. These lesions included forty-six instances of malignant tumor, ten of heart disease, twelve of nephritis, seven of cerebral thrombosis and infarction.

### Lobar Pneumonia

Lobar pneumonia was encountered thirteen times in this series of necropsies. In twelve instances it was the primary cause of illness, and in only one case did lobar pneumonia follow as a complication of an operative procedure. This is of interest, when considered in connection with the frequency of pulmonary embolism and infarction which so often gives rise to a diagnosis of postoperative pneumonia.

### Miscellaneous

Besides the larger groups of well defined types of pulmonary lesions, others were met with in smaller numbers. These included acute and chronic bronchitis, purulent bronchitis, emphysema, pneumoconiosis, anthracosis, and abscesses solitary, multiple, and miliary. There were eleven cases in which tuberculosis of a degree sufficient to constitute a major complication was found. Tumor of the lung was found in twenty-one instances, of which seven were bronchiogenic carcinoma, and fourteen metastatic, mostly carcinoma.

### Clinical Applications

Studies of this sort are unavoidably statistical, and their recital possibly dreary.

They offer, however, some suggestions as to the clinical interpretation of the frequently indefinite confusing or relatively slight physical signs which appear in persons seriously ill with other diseases. In the patient convalescent from an operation, or suffering from some illness, a change in condition appears, with slight cough, accession of fever, abnormal dulness at some point in the chest, râles with or without recognizable significant change in breath sounds, or more stormy symptoms of severe pain in the chest, cough, blood-stained expectoration, appear. What is the probable nature of the new complication, and to what extent does it modify the prognosis?

The answers to these questions are in some cases difficult; in others they are extremely easy, if only the probabilities are borne in mind. The difficulty is that often we do not think of them.

Sudden chest pain, with cough, and blood-stained or bloody expectoration and subsequent fever in a patient convalescing from an operation is likely to be due to small or medium sized emboli with infarction of the

lung, and rarely to the frequently suggested postoperative lobar pneumonia. In patients without previous evidence of gross infection, these infarcts are likely to be simple, and many of them heal. Infarcts coming from grossly infected wound fields are likely to be septic, and many of these progress to multiple lung abscesses with ultimate death. In non-surgical patients about half the cases of pulmonary infarcts originate from intracardiac thrombi, in the course of valvular or myocardial disease.

Pulmonary complications suggestive of pneumonia in patients with evident dilatation of stomach or other gastro-intestinal obstruction, or in patients with diaphragmatic spasms, hiccough, or vomiting, are likely to be due to aspiration of stomach contents and constitute the large group of aspiration pneumonia. Hiccough and slight eructations are more common than frank vomiting in these patients, possibly because patients able to vomit vigorously are more often in possession of active tracheo-bronchial reflexes and are better able to expel such foreign material as enters the trachea.

Aspiration pneumonia is most likely to occur in patients with gastro-intestinal obstruction and dilatation, and resultant vomiting or eructation frequent after operations on these structures, and in patients in coma or severely prostrated by illness. The use of continuous drainage of the stomach in such patients has reduced the incidence of this form of pneumonia.

In patients greatly weakened by long illness, especially those with tumors such as in the late stages of metastatic carcinoma, the process in the lung giving rise to physical signs is likely to be the usually recognized type of bronchopneumonia.

One old clinical maxim, not however specially demonstrated by the material under discussion, is helpful in determining the order of events where an obscure abdominal condition with fever is combined with evidence of infection in the chest, and suspected or demonstrable empyema. Usually it will be found that the original trouble was in the abdomen, such as a missed and often retrocecal appendicitis, and that the infection in the chest is secondary. Infection from chest to abdomen is rare.

Pulmonary complications are frequent in persons who die from any cause. Some of these pulmonary lesions are incidental and of little importance; many, however, are



major complications. The figures of necropsy findings suggest that we can do better than merely to set down the clinical diagnosis of "terminal bronchopneumonia."

Often a consideration of symptomatology

and the recalling of probabilities will permit a more correct diagnosis of pulmonary embolism or aspiration pneumonia; and early recognition of possibilities may lead to the prevention of aspiration pneumonia.

## SPONTANEOUS RUPTURE OF THE UTERUS FOLLOWING A PREVIOUS CESAREAN SECTION

### Case Report and Discussion

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During the past few years there has been a decided improvement in prenatal care and of consequence, more frequent surgical deliveries in an effort to save mothers from unnecessary trauma or to circumvent distocias of labor. Hence, cesarean section has increased in frequency.

As a result of this increase in cesarean operations we are likely to see more cases of rupture of the uterus during pregnancies subsequent to cesarean section. It is wise, therefore, to examine into the causes of such ruptures with a view to correct the faults of technic where possible.

What are the causes of rupture following cesarean section? LaMariana<sup>11</sup> classifies them as follows:

1. Implantation of the placenta at the sight of the scar with invasion and weakening of the scar by embryonal elements.

2. Repeated cesarean section.

3. Overdistension.

4. Imperfect consolidation of the scar due to:

- a. Ill chosen location of the wound,

- b. Infection of the wound,

- c. Suture of the placental site,

- d. Improper suture,

- e. Imperfect technic in suturing.

The outstanding features of rupture of the uterus during labor are threefold: (a) lack of progress of the labor, (b) sudden sharp pain in the lower abdomen, and (c) symptoms of profound shock.

If the rupture occurs when the patient is not on labor, the clinical picture resembles that of ruptured ectopic gestation with pain the predominant symptom. The chief difference is that ectopic pregnancy usually occurs early in pregnancy while rupture of the uterus is observed in patients who have entered the third trimester of pregnancy.

Every so often the tear in the uterus will occur gradually and there will be very little hemorrhage into the abdominal cavity. In that event, symptoms will be mild or

even absent.<sup>17</sup> The following case belongs in this category.

### Case History

M. S., white, female, aged twenty-five years, para two. The first day of the patient's last menstrual period was December 10, 1935, and her expected date of confinement was September 17, 1936. She was under medical supervision after the second month of pregnancy. Except for nausea during the last month of the first trimester, the patient had no untoward symptoms until June 29, when she experienced an acute gastro-intestinal disturbance with marked abdominal distension. Two days later she began to vomit persistently and had a slight bloody vaginal discharge. Abdominal pain was absent.

Examination on July 1 revealed: temperature 99.6° F., pulse 132, respiration 20. The abdomen was tense and tympanitic. Strong, regular, fetal heart tones were heard in all four abdominal quadrants. The rate was 140 per minute. The patient's blood pressure was 100/60. Her urine was negative. Under treatment the symptoms rapidly subsided. During the next six weeks the patient lost eleven pounds. Examination on August 14 disclosed that the abdomen had definitely decreased in size, and the uterus had descended to below the level of the umbilicus. Fetal heart tones could not be heard after July 1. From August 14 to September 21 no fetal parts could be felt.

X-ray examination of the abdomen, made September 1, located the fetus under the left dome of the diaphragm. The roentgenologist concluded that the fetus was dead because of the overlapping of the bones of the skull. The high position of the head of the fetus indicated that it was extra-uterine. The past history was negative except for an appendectomy, for pneumonia and for a cesarean section performed by the author on February 1, 1935. This was a classical section and was done because x-rays revealed a face presentation of an overly large fetus and because a twenty-four hour test of labor showed no progress.

From July 1, 1936, until the patient was admitted to the hospital on October 6, 1936, for operation, she enjoyed good health and experienced no symptoms whatsoever from the rupture of the uterus and subsequent abdominal abortion. Because no emer-

This case presents several unusual features. First, is the fact that when this patient's uterus ruptured she had so few symptoms. There was no shock, probably because

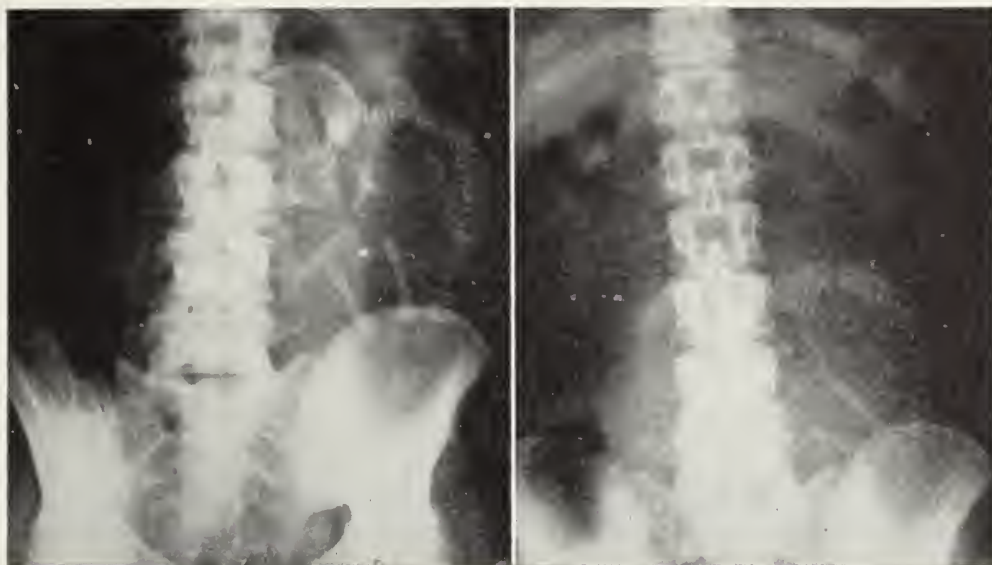


Fig. 1. (*left*) Radiograph of abdomen showing head of fetus under dome of left diaphragm (taken 8-31-36).

Fig. 2. (*right*) Radiograph of abdomen one month later, showing descent of fetus to mid-abdomen (taken 10-1-36).

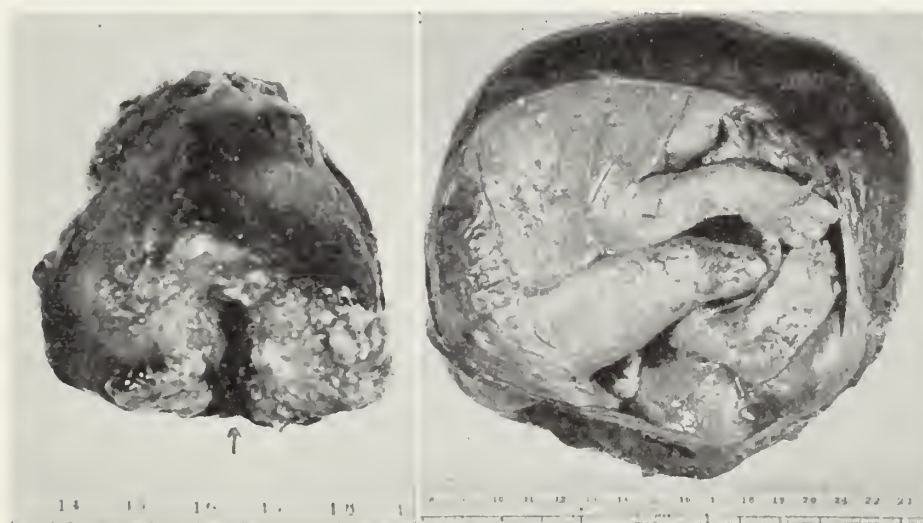


Fig. 3. (*left*) The uterus. Arrow indicates rent in the fundus of the uterus.

Fig. 4. (*right*) The fetus in amniotic sac.

gency existed, operation was deferred until the expected date of confinement had passed.

The patient was operated on October 6. The abdominal cavity was opened through a midline sub-umbilical incision. A mass was found lying in the lower half of the abdominal cavity. The mass was adherent anteriorly to the large intestines and posteriorly to the uterus and adnexæ. The mass was a six months dead fetus with the amniotic sac intact. The pregnancy was freed from these adhesions and removed.

The uterus was the size of a normal non-pregnant uterus with a rent in the fundic portion about 6 cm. long. This was the site of the previous cesarean scar. The margins of the wound were well organized. A subtotal hysterectomy was performed, both tubes and ovaries being left intact. Convalescence was uneventful and the patient was discharged from the hospital on the eleventh post-operative day.

the cesarean scar gave way gradually and the fetus acted as a tampon to control hemorrhage from the tear.

The second unusual feature noted was complete lack of pain. Pain is usually the cardinal symptom of rupture. Its absence in this case added to the difficulty of diagnosis. The slow tearing of the uterus plus a low threshold for pain no doubt accounts for the lack of this symptom.

#### Diagnosis

Certain cases of rupture of the uterus, such as the foregoing, present difficulties of



diagnosis. These difficulties are ably set forth by Devraigne, Ravina and LeRoy.<sup>20</sup>

When, in the course of pregnancy, the gravid woman experiences symptoms suggestive of rupture of the uterus, but the diagnosis is in doubt, it is well, as Colvin and McCord<sup>2</sup> suggest, to note the absence of Braxton-Hicks contractions and the inability of the mass to respond to stimulation.

Should the diagnosis still be obscure, the Friedman test may be utilized as advocated by Goldberger, Salmon and Frank.<sup>5</sup> But in all obscure and doubtful cases much valuable information, which will frequently clinch the diagnosis, can be obtained by x-ray examination of the abdomen.

The value of x-ray in such cases is usually overlooked. Yet abdominal x-ray will frequently show an abnormal position of the fetus, suggesting that the pregnancy is extra-uterine. The question of whether the fetus is still alive can be determined at times only by x-ray evidence. Overlapping of the skull bones indicates a dead fetus. The information thus gained by x-ray when considered with the findings on physical examination, the patient's history, and observations as to lack of progress of the pregnancy, should render even the most difficult case diagnosable.

A review of a large number of cases of rupture of the uterus following previous cesarean section<sup>1,3,6,10,12,13,14,16,17,18,21</sup> indicates that all such ruptures have followed the so-called classical section. Perhaps, if the low cervical cesarean section supplants the classical operation as the one of choice, rupture through uterine scars will be materially lessened.

That a change to the cervical portion of the uterus as the site for incision should greatly lessen the likelihood of rupture, will be evident if we reconsider the etiology of this accident. As has been stated, the reasons for rupture following cesarean section are: overdistension, weakening of the scar by invasion of embryonal elements and imperfect consolidation of the scar. Obviously, overdistension and weakening of the scar are not so apt to occur in the cervical portion of the uterus.

The last factor, the strength of the cesarean scar, is not altogether a matter of its location. As Davis<sup>21</sup> points out, there is a wide variation in the characteristics of each individual regarding the type of muscles and fascia possessed as well as the ability of

the body to form scar tissue. Nevertheless, a scar in the fundus of the uterus is in a more vulnerable location than one in the cervical region.

Hence, I believe that the low cervical section offers a valuable method for the prevention of rupture of the uterus in pregnancies that occur after this operation. But until the low cervical operation becomes popularized, we will have many patients who have had a previous section in the classical manner. In these cases one should be ever mindful of the possibility of rupture of the old scar, especially during the third trimester and during labor.

### Summary

1. A case of ruptured uterus, which occurred during the sixth month of pregnancy, was reported. The case was unusual in that the patient had no pain and no symptoms of shock at the time of rupture. The site of rupture was through the scar of a previous cesarean section.

2. The value of x-ray of the abdomen in making the diagnosis in obscure cases of ruptured uterus, was stressed.

3. Because all cases of rupture of the uterus reported as having occurred after previous cesarean sections have been observed only after the so-called classical section, the prophylactic value of the low cervical cesarean operation was discussed.

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## OSTEOPOROSIS DUE TO CARBOHYDRATE AND CALCIUM METABOLISM DISTURBANCES\*

### Pain, Headache and Weakness Associated with Osteoporosis

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The condition osteoporosis produces pain in the extremities (upper and lower), backache, headache and muscular weakness. In advanced cases there is usually present swelling of both extremities. Because the diagnosis of rheumatism or neurosis is so often erroneously made in patients with osteoporosis, it is believed that more attention should be paid to its symptomatology.

This article will present data tending to show that disturbance in carbohydrate and calcium metabolism is responsible for the production of osteoporosis.

In eliciting the history of thirty osteoporotic patients, the earliest complaint was one of tiredness. Muscular effort and standing for a length of time resulted in this complaint of tired muscles. In addition, the majority stated that they had backache, radiating anteriorly onto the chest and abdomen. Pain in the arms and legs with weakness was usually present.

Headache, while not present in all cases, was complained of by those in whom the roentgenogram showed osteoporosis of the skull. It is one of the leading symptoms in these patients. Dizziness is also one of the most frequent complaints and is probably due to the accompanying arteriosclerosis.

The duration of these symptoms was variously given as ranging from one to fifteen years, the majority averaging four to six years. It is worthy of note, from the standpoint of diagnosis, that many years (four to five years) elapse between the subjective complaint of backache, headache and pains in the extremities and the demonstrable roentgen findings of osteoporosis. This discrepancy between subjective complaints and objective findings leads to the unjust diagnosis of neurosis.

The swelling of the extremities seems to appear late in the course of the disease,

after the osteoporosis is advanced and readily shown by roentgenograms.

The following case shows how long symptoms may be present before roentgenograms reveal objective changes.

A female patient, aged sixty-one, complained of backache for a period of twenty-five years. Tiredness and muscular weakness were also present for about the same length of time. Several roentgen studies of the spine were reported as negative. Headache, generalized in character, was complained of for fourteen years. Twelve years ago she was confined to bed for three months because of right sided sciatica. Since that time pain in both legs and arms as well as weakness of the lower extremities was very troublesome. Aching between the shoulders and down the arms was also complained of. During this period of semi-invalidism the diagnosis of neurosis was made by several physicians. It was not until three years ago that roentgenograms showed osteoporosis of the whole skeleton. This was so marked and her pains so severe that the late Dr. Max Ballin removed two parathyroid glands. These were reported as normal both grossly and microscopically. Only temporary relief was obtained, perhaps no more than would result from the enforced bed rest.

In fact the osteoporosis has progressed and a calcified fibroid has developed, showing that this procedure did not arrest the process.

Of interest is the statement so often made that power seemed to be lacking in the leg muscles as well as severe pain being felt in the metatarsal arch region. This resulted in limping. The muscles of the arms and legs are often very tender and spastic, the pain being so severe that it incapacitates the pa-

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tient. Tenseness and drawing sensation in the thigh muscles is complained of. The extremities are closely guarded lest the least trauma would cause pain. The pain and swelling is not confined to the lower extremities, but involves the upper as well.

Weakness of the arms, legs and back muscles is almost always present. Backache is very troublesome but that it is not due to crushing of the vertebræ with resultant nerve pressure is shown by the fact that this is a very early symptom present long before the roentgenograms show any abnormalities.

Headache is usually present in those patients having osteoporosis in the skull. The natural assumption in view of the bone pains elsewhere is that the osteoporosis of the skull is responsible for the headache. This explanation would be helpful in understanding some of the obscure types of headache which are encountered.

The cause of the bone pains in osteoporosis is not entirely clear, but certain facts are suggestive, as will be shown later on in the article. I am of the opinion that it is on a vascular-neurogenic basis involving the periosteum. Support for this view may be found in the condition post-traumatic bone atrophy, known as Sudeck's atrophy. This is a *localized* osteoporosis resulting from trauma, often trivial in severity. Gurd<sup>8</sup> reviewed several cases of this type. He noted that pain is a predominant factor together with extreme loss of function. Swelling and evident atrophy of the skin and subcutaneous tissue are characteristically present. Pathological studies, he says, prove a uniform loss of bony substance and not merely the depletion of mineral salts. He is of the opinion that the explanation of the condition would appear to be that through a stimulus of the reflex arc with consequent local hyperemia, bone absorption is brought about. In Sudeck's localized osteoporosis the vascular changes are very marked and the bone changes appear soon after the trauma.

I had occasion to follow the localized form very closely because of personal experience.

While attempting to produce osteoporosis and Paget's disease in dogs by the use of anterior pituitary growth hormone and parathyroid extract, I accidentally dropped a heavy syringe to which was attached a long needle. In order to break the fall of the syringe I stretched out my left foot. The needle entered the tongue of the shoe and penetrated between the astragalus and navicular bones. Within twelve hours I had a chill followed by severe pain and swelling of the foot. The hyperemia,

swelling and pain became very marked, the latter requiring morph. gr.  $\frac{1}{2}$  (0.03). The foot became intensely swollen and cyanotic when in the dependent position. Two weeks after the injury atrophy of the tarsal bones was already evident in the roentgenograms, and within four weeks had involved all the bones of the foot. The swelling, hyperemia and cyanosis were present for eight weeks. Difficulty in walking due to pain and lack of power was present for six months. The metatarsal region at the ball of the foot was particularly painful so that walking on the outer surface was necessary. A minor accident resulted in a fracture of a metatarsal bone. Walking with a limp was resumed at the end of eight weeks. Unfortunately we were not as successful in producing osteoporosis in the dogs.

The intense hyperemia and cyanosis as evidence of interference with the vascular supply to the bone results in a marked atrophy as well as demineralization of the bones. The difference between the localized and generalized form of osteoporosis would seem to be one of time element and the intensity of the vascular changes. Of course in the former the etiology is trauma, whereas in the latter, I am assuming a metabolic-vascular disturbance. The acute type has intense and rapid vascular changes of temporary nature which interfere with the blood supply to the bone, whereas in chronic osteoporosis of metabolic origin, the onset is slower and more gradual and the vascular changes are permanent.

#### Constitutional and Metabolic Factors

In a previous paper, Adler and I<sup>15</sup> summarized a report on 26 patients in each group of Paget's disease and osteoporosis. It was pointed out that osteoporosis is the first stage of Paget's disease. Recently van der Heide<sup>24</sup> called attention to factors indicating a connection between circumscribed cranial osteoporosis and Paget's disease.

A part of the summary of our article is as follows:

Of twenty patients with osteoporosis who had dextrose tolerance tests, eighteen, or 90 per cent, gave a diabetic type curve. Thirty-four per cent of twenty-six patients gave a familial history of diabetes; seventy per cent a history of obesity; and 84 per cent of tallness.

Sixty-five per cent of osteoporotic patients had goiters, 24 per cent were calcified; 38 per cent had thyroidectomy; 27 per cent had thyroparathyroidectomy.

Forty-seven and six-tenths per cent of females had uterine fibroids; 30 per cent were calcified. Fifteen per cent had renal calculi and 16 per cent had gallstones.

Thyroparathyroidectomy or thyroidecto-

my had no permanent influence on the bone lesions, nor did these procedures eliminate the diabetic type of curve present in both groups of patients. It has been shown by several workers that a toxic goiter is often associated with osteoporosis. In this condition there is an increased output of calcium which is corrected by thyroidectomy. We suggested that what benefits were achieved by operation could be understood by a slowing effect on carbohydrate metabolism and also a decrease in calcium-phosphorus metabolism. Calcium and phosphorus are concerned with carbohydrate metabolism; all three are of greatest importance in the bone diseases under discussion (Paget's and osteoporosis).

In addition to the above, the family history of thirty osteoporotic patients shows that in 68.7 per cent there was a history of arteriosclerosis; that is, some member of the immediate family died from the effects of cardio-vascular-renal disease. In the family of one patient, the father, mother and a brother died of cerebral apoplexy, one brother died of coronary thrombosis and one living brother had diabetes.

With the inherited background of diabetes and obesity, it is logical to assume that the osteoporotic is constitutionally predisposed to arteriosclerosis. The association of diabetes, obesity and arteriosclerosis is almost universally accepted.

The foregoing data suggest that carbohydrate metabolism is concerned with the deposition of calcium in the tissues. Experimentally we have been able to substantiate this.

### Experiments

A short report on our experiments is as follows: We injected dogs with pituitary growth hormone and parathyroid extract over a period of 237 days. (Average 358 c.c. pituitary growth hormone; 13,000 units parathyroid extract.) The dog receiving only parathyroid extract showed but few deposits of calcium in the kidney and no changes in the bone marrow, whereas the dogs receiving the combined extracts showed extensive calcium deposits in the kidneys and massive replacement of bone marrow by calcium. We have just completed repeating these experiments but with the addition of a measured *high carbohydrate* diet. While our data are yet incomplete on this latter group, we can say that within a short-

er time (180 days) the dogs on the high carbohydrate diet show more intense and more numerous deposits of calcium in the kidney. This suggests that the high carbohydrate diet influences calcium metabolism. Apparently the high carbohydrate diet speeds up calcium metabolism, possibly mobilizes it. No final conclusions can be reached from so little experimental work, but it is at least suggestive.

As is known, calcium and phosphorus are intimately linked. As Hunter<sup>11</sup> says, though the most dramatic effects of parathormone are on the blood calcium and calcium excretion, there is evidence that its primary effect is on phosphorus excretion. It is well known that phosphorus compounds are in some way essential to the storage or utilization of carbohydrate and are concerned with acid base equilibrium and they are essential to the deposition of bone.

Concerning bone phosphatase, Hunter says that there seems little doubt that phosphatase plays a part in the chain of events by which the deposition of calcium phosphate in growing bones is brought about. It is evident that carbohydrate metabolism, calcium and phosphorus are very closely associated.

A further relationship between carbohydrate metabolism and calcium is shown by the fact that calcium and parathyroid extract act like insulin in lowering the blood sugar. (Johnson,<sup>12</sup> Ferrannini,<sup>7</sup> Murphy, Reynolds and Moehlig.<sup>17</sup>)

We found that dogs receiving parathyroid extract over a long period of time developed an immunity to increase in blood calcium, but when glucose was added to the diet the blood calcium level rose immediately, whereas the blood sugar, phosphorus and phosphatase were lowered.

Despite the very definite and extensive microscopic changes found in the bones of the dogs receiving growth hormone and parathyroid extract, it was disappointing that the roentgenograms failed to show any detectable changes. Because of this, it seems most likely that the metabolic-vascular disturbances precede the objective findings for a long period. This would explain why the clinical diagnosis of neurosis is often made.

In intoxication with vitamin D, Steck and associates<sup>22</sup> found that the increased excretion of calcium in this condition is not due solely to removal of the microscopic de-



posits in the soft tissues because the increase in the urine begins before there is any microscopic or chemical evidence of excessive deposition in soft tissues. They believe that first cellular degeneration occurs, more commonly in kidney, then calcium deposition follows. From their work they also believe that, until further information is available, arteriosclerosis should probably be considered a contraindication to the administration of massive doses of vitamin D. We are of the same opinion in regard to the giving of calcium, cod liver oil, haliver oil, etc., in osteoporosis. The diagnosis of demineralization of the bones is usually interpreted as due to faulty mineral metabolism and leads to the giving of calcium in various forms. This would seem to be adding fuel to the fire, for the various tissues already have an overabundance of calcium. Osteoporotic patients almost always have arteriosclerosis, so that the giving of cod liver oil, etc., would have a tendency to increase this condition. They are of course at an age level where arteriosclerosis is frequent. In our series the average age was 52 years.

As previously pointed out, the constitutional factors of familial obesity, tallness, diabetes mellitus, and cardio-vascular-renal disease would seem to furnish the hereditary background for the production of osteoporosis. Elsewhere it was stated that overactivity of the pituitary gland could well explain the constitutional factors in the etiology of osteoporosis. The pituitary gland is concerned with fat metabolism, osseous development, and carbohydrate metabolism. There is also some evidence that this gland is involved in cardio-vascular-renal disease. (Cushing,<sup>5</sup> Anselmino and Hoffmann,<sup>2</sup> Moehlig and Osius.<sup>16</sup>)

In hyperpituitary states, such as acromegaly and pituitary basophilia, osteoporosis is usually present. Furthermore, the lowered glucose tolerance to the point of frank diabetes is a part of these states. That calcium disturbances are present in hyperpituitary states is also suggested by the experimental work of Anselmino, Hoffmann and Herold,<sup>3</sup> and Hertz and Kranes.<sup>10</sup> They found that injections of anterior pituitary extract produce hyperplasia of the parathyroids. Furthermore the former workers found that this extract increased the blood calcium but this did not occur if parathyroidectomy was

done, showing that the pituitary acted on the parathyroids.

In a case of acromegaly, Scriver and Bryan<sup>21</sup> noted a greater excretion of calcium than normal. They do not believe that there is evidence of hyperparathyroidism in these patients.

It is of interest that symptoms of diabetes mellitus include polyuria and polydipsia and these are also present in hypercalcemic states such as osteitis fibrosa cystica. This suggests that in the former condition the disturbed carbohydrate metabolism upsets or activates calcium metabolism and this in turn affects the kidneys. In the latter condition the hypercalcemic state affects the kidneys, producing polyuria and polydipsia.

We have encountered several cases of diabetes with extensive osteoporosis leading to crushing of the vertebræ.

Root, White and Marble,<sup>20</sup> on the other hand, noted osteoporosis with crushing of the vertebræ in but two cases among 12,000 patients who have applied for diagnosis or treatment of diabetes over a period of thirty-five years. I feel, however, that osteoporosis *without crushing* of the vertebræ is common in diabetes and certainly in view of the lowered tolerance of osteoporotic patients, it would seem logical to find osteoporosis in diabetics. The aforementioned authors say, "It is true that in some patients fractures have seemed to occur with slight trauma." They state that except for the report of Morrison and Bogan, who found delayed development of bone, narrowness of the shaft and thinness of the cortex with atrophy of the bone in some cases of diabetes in children, no systematic study of roentgenograms of bones of persons with diabetes is known to us. "At present no accurate statement is possible as to whether or not decalcification of bone is more common in persons with diabetes than in persons without diabetes." These writers have covered the literature on the subject of calcium deposition in diabetes. Joslin,<sup>13</sup> Atchley and associates<sup>4</sup> showed that in diabetic acidosis and acidosis due to other causes there is an increased excretion of calcium in the urine. Root, White and Marble say that from a review of the older literature one would infer that in diabetes mellitus in general there is an increased excretion of calcium. For instance, Falta and Whitney,<sup>6</sup> from experiments on depancreatized dogs, believed that

the negative calcium balance and the calcium excretion, which were observed, were out of proportion to any degree of acidosis present.

Rodriguez-Candela<sup>18,19</sup> believes that the pancreas influences calcium and phosphorus metabolism. He noted that there was a greater excretion of calcium in the depancreatized dogs than in the normal.

Root and associates say that instances of extensive localized deposition of calcium are all too common in persons with diabetes. In the days before insulin was used, calcification of the arteries was the rule in patients with diabetes of more than five years' duration.

Renal calculi associated with bone disturbances are unusually frequent. We are at present attempting to show a relationship between carbohydrate metabolism and renal calculi. We noted the frequent combination of diabetes mellitus and renal calculi.

For further support to calcium and carbohydrate metabolism association may be added the following fact: A significant loss of calcium by the bowel occurs in chronic pancreatitis, in which large amounts of insoluble calcium salts are formed and excreted with the fatty stools.

Dr. F. W. Hartman<sup>9</sup> of Ford Hospital\* discussed a patient coming to autopsy who showed extensive decalcification of the skeleton with extensive generalized osteitis fibrosa cystica.

Thirty-five-year old man, first seen in 1921, in the following two years developed a picture resembling Paget's disease, lost two inches in height, legs became curved, calcium ranged from 9 to 16.5 milligrams, phosphorus 2 to 3 milligrams. Biopsy of bones in 1924 showed osteitis fibrosa cystica. Fracture of right femur occurred in 1926 while sneezing. He died in 1927. The skeleton was very soft, extensive osteitis fibrosa cystica, irregular cyst formations around the fracture of the femur; thyroid nothing abnormal, *no abnormality in a piece of parathyroid attached to the thyroid; pancreas showed a very unusual picture, smaller than normal, very firm, pale, scarred appearance, cutting with a rasping sound and gritty resistance felt throughout, the lobular markings have disappeared, irregular cystic dilatation in the otherwise fibrous organ. Microscopically, chronic fibrous pancreatitis with some intact islets.* Chronic nephritis with retention cysts; in the right kidney a minute adenoma seven by five millimeters (microscopically benign) was found. Thymus showed nothing abnormal. Pituitary, anterior and posterior parts had the usual cellular appearance, in the intermediate part numerous acinar structures with colloid material. Two parathyroids were hyperplastic; the third contained an adenoma.

Wilder<sup>25</sup> reports the case of a thirty-year-old woman who had osteoporosis of the spine, ribs, pelvis and femur with calcified mesenteric glands. Glycosuria was present. She had a cancer of the pancreas. In another similar case reported by Wilder the patient had osteoporosis of the thoracic and lumbar vertebræ with compression. At autopsy an abscess of the pancreas was found. Calcium may be excreted through the pancreas as shown by Ägren<sup>1</sup> and Loeper and associates.<sup>14</sup>

One is forced to the conclusion that carbohydrate metabolism disturbances lead to calcium disturbances with consequent skeletal changes and deposits of calcium in the soft tissues.

Tetany may be overcome by lactose or glucose intravenously, showing that carbohydrate mobilizes calcium. Our experiments as well as others previously cited show the effect of glucose on elevating blood calcium.

The association of diabetes mellitus and cataracts again suggests the close association of calcium and carbohydrate metabolism. Updegraff<sup>23</sup> showed that ocular lenses (in the advanced stages of cataract) contain large amounts of calcium.

That the parathyroids are not the primary factor in the etiology of osteoporosis is shown by the fact that parathyroidectomy of two and sometimes three parathyroid glands (reported normal grossly and microscopically) in five cases of osteoporosis did not stop the progress of the condition nor alleviate the pain.

It would seem logical that whatever influences carbohydrate metabolism would also influence calcium metabolism. One might term them interlocking metabolisms.

One can more readily understand the production of arteriosclerosis, bone changes, accompanying disturbed carbohydrate metabolism by this process of reasoning.

The speed of carbohydrate metabolism is reflected in calcium metabolism. Pancreatic changes with resulting sugar metabolism upset would seem to influence calcium metabolism possibly by way of the parathyroids. It is also logical to suppose that primary parathyroid disturbances would lead to pancreatic changes. Hartman's patient, cited previously, illustrates these interlocking disturbances. Which was primary (pancreas or parathyroid), is of course not known.

Such conditions as hypopituitarism pres-

\*Case reported through courtesy of Dr. Hartman.



ent during the osseous developmental period with its retarded carbohydrate metabolism are often accompanied by retarded osseous development.

The fondness for sweets that children usually have is probably Nature's way of speeding up carbohydrate metabolism (and therefore, according to the opinion advanced, calcium metabolism) in order to produce good osseous development.

Studies directed towards clarifying the carbohydrate-calcium metabolism relationships will do much to solve many clinical-metabolic problems.

Osteoporosis is the first stage of Paget's disease. In Paget's disease the osteoporosis goes on to a low grade osteoid formation with deposition of calcium. Since in both osteoporosis and Paget's disease calcium deposits are frequently found in the soft tissues, the thought suggests itself that in Paget's disease the osseous system becomes a depository for calcium, like the soft tissues, only in a much greater degree than is normal even for bone. In other words, fixation of large amounts of calcium in the bones with osteoblast activity leads to Paget's disease. From patients of this type whom we have studied, it was found that the output of urinary calcium was less than normal, suggesting that this element is retained in abnormal amounts.

### Summary

The clinical symptoms of osteoporosis are given. Briefly, these are severe pain in the extremities, backache, and frequently headache. Weakness, with lack of power in the extremities as well as the severe pain, often incapacitates the patient. Advanced cases usually have swelling of the extremities. Symptoms are present long before the x-ray is able to demonstrate the osseous changes, often leading to the diagnosis of neurosis.

The history of these patients shows that 68.7 per cent of the immediate family died of cardio-vascular-renal disease. In addition there is a high incidence of familial diabetes, obesity and tallness. It is suggested that the pituitary gland function could explain these constitutional metabolic factors present in this disease.

Evidence is presented to show that carbohydrate metabolism affects calcium metabolism and the deposition of calcium in the tissues.

Preliminary experimental work on dogs shows that a high carbohydrate diet plus injections of parathyroid and anterior pituitary growth extracts produces greater deposits in the kidney in a shorter time than in those on a regular diet.

Carbohydrate metabolism disturbances lead to calcium disturbances with consequent skeletal changes and deposits in the soft tissues. The association of diabetes and arteriosclerosis may be understood as due in part to a concomitant calcium disturbance associated with carbohydrate metabolism disturbance.

Factors influencing carbohydrate metabolism would at the same time influence calcium metabolism. These metabolisms are therefore interlocking. Pancreatic disease with carbohydrate metabolism disturbance may lead to calcium disturbances manifested, among other things, in the osseous system.

In osteoporosis (the first stage of Paget's disease) and Paget's disease, there is frequently present deposits of calcium in soft tissues. It is suggested that in the latter disease there is an abnormal fixation of calcium in the osseous system with osteoblast activity leading to the osteoid formation.

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## TREATMENT OF WOUNDS OF THE HAND\*

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The treatment of wounds takes us through nearly the entire historical era of medicine. Let us pause to pay a sincere tribute to Hippocrates,<sup>3</sup> who as early as 360 B.C. reduced fractures and dislocations.

During the 16th century, barbers and bath keepers opened veins and bandaged wounds. The king of Hungary at this time had to advertise all over Europe for a surgeon to cure him of a wound. But following the Dark Ages and Renaissance, real progress began to be made. Men like John Hunter<sup>4</sup> became leaders in helping to elevate surgery to a high place among the sciences, and were real pioneers in the treatment of gunshot wounds.

Wars have had a noticeable and progressive effect on various phases of wound treatment, particularly the last great World War, which taught us much about tetanus, plastic surgery, and many other things that we do now with very little concern.

As we merge into our modern era, it seems hardly fair, even in so brief an historical prelude, to pass by without mentioning the names of such energetic workers as Allen Kanavel, Sumner Koch, and Sterling Bunell, along with many others who are leaders and teachers in surgery. These men have contributed much to the subject of hand injuries.

It is the purpose of the writer to discuss but a few of the things that seem to be important and helpful in the prophylaxis and treatment of wounds of the hand.

The care of the injured hand seems a paramount subject because man's hand is one of his most important anatomical appendages, and because most of its treatment falls into the realm of minor surgery and is altogether too frequently neglected.

The hand is a highly efficient and sensitive mechanism. The many joints with their tendons sliding smoothly over and under, held in place by ring ligaments, and lubricated by synovial fluid, are so perfect in construction that man becomes crude and helpless in attempts to reconstruct or repair nature's original. The specialized tactile nerve endings in the finger tips, the protective nails, and the special type of skin on the palmar surfaces all are impossible to replace once they have been destroyed. The many movements and uses that the hand and its digits may become proficient in executing make it valuable, and indeed practically characteristic of the human.

### Prophylaxis

*Safety.*—Along the lines of prophylaxis, much is being done in this country by safety engineers. The International Safety Congress meets each year in one of our leading cities, with the sole purpose of presenting worthy advancements in safety appliances to protect not only the factory worker but people on streets, in traffic, and in other pursuits of life.

\*Presented at the Staff Surgery Clinic, Hurley Hospital, January 6, 1938.



# WOUNDS OF THE HAND—SPENCER

TABLE I

Types of Occupation	Abra-sions	Amputations	Burns	TYPES OF HAND INJURIES SUSTAINED						
				Contu-sions	Frac-tures	Punc-ture Wds. &FB's	Lacera-tions	Nail Wounds	Sprains	Severed Tendon
Assembly			5	5		12	23			
Cabinet Maker	2	2				4	19			
Carpenters	2	3			1	15	9			2
Die-makers				2			16	1		12
Drill Operators							9	2		1
Electricians			8			4				2
Foremen			2				9		2	1
Grinders	4		20				20			
Mill workers			5							
Moulding	5		4		4		6	5		
Painters	6					6				
Panelers							12			
Polishers	12						3			
Punchpress ops.		25		29	15	6	30			2
Repair men		1		1			15			
Salvagers					1	14		2		
Saw operators		5					20			
Shifters			6							
Shipping clerks				9			1			
Solderers			15							
Stock boys				5			23			
Tool makers		1		6			14			
Trimmers				12		11	11			
Truckers				8		10				
Winding coils						15	12			
Wire cutters							13			

Safety departments in the larger industries have been the cause of great reductions in hazards which used to claim many hands and arms in days gone by. If an accident occurs involving the loss of a finger in a factory today, it becomes a whole department's job to thoroughly and exhaustively determine the cause of the accident, so that its repetition may possibly be prevented.

It has also been well demonstrated in many large industrial dispensaries that im-

mediate and wise first aid treatment of even the smallest wounds of the hand reduce the numbers of lost time accidents many fold. De Tarnowsky<sup>6</sup> says concerning this point, however, that "It is axiomatic that illogical, unclean, or meddlesome 'first aid' is more dangerous than no treatment . . . the hemorrhage . . . cleanses the wound efficiently . . . and the magic of iodine will not offset the introduction into the devitalized tissue of bacteria normally inhabiting the skin as

saprophytes." Even with these precautions, we are too often called upon to see what might have been a simple scratch complicated by a raging lymphangitis. Deaths have resulted many times from hand infections which might have been prevented. In a classification by the National Safety Council<sup>11</sup> last year from the reports of four states in over 3,000 hand infections there were 22 deaths, 188 permanent disabilities, and 2,887 temporary disabilities.

The following table of a group of industrial hand injuries seen by the writer during the past three or four years seems to show an apparent relationship of certain types of wounds to various forms of occupations. The interesting point here is a surprisingly small number of major injuries such as severed tendons, hand and multiple finger amputation, et cetera.

*General Condition of Patient.*—It is probably necessary to say only a few words here so that we may not overlook the fact that before the wound itself is touched, the patient's general condition must be made secure. Wounds of the hand do not often cause severe shock, but syncope often occurs, which demands immediate attention. With the *head down, patient preferably lying down*, inhalation of aromatic spirits of ammonia will usually accomplish the desired result. Here it should be remembered that control of hemorrhage from hand wounds may usually be taken care of by simply a clean, firm dressing over the wound . . . this should be told to the laity at every opportunity.

*Tetanus Antitoxin.*—While speaking of prophylaxis, it should not be forgotten that in wounds that have been contaminated by spores of clostridium tetani, the prophylactic serum of 1,500 units in adults should be given with care and after carefully ascertaining whether or not the patient is sensitive to horse serum. It is sometimes difficult to decide whether or not such contamination has occurred. Nail wounds are common offenders, especially a rusty nail from the ground, because, of course, a nail (even though rusty) on top of a fence exposed to the open air and sun does not as a rule cause tetanus infection. Certain types of foundry workers, though their hands are black with molding sand, do not usually have trouble, for the molding sand has been sterilized and resterilized by the molten metal.

An interesting discussion on this subject appeared recently in the current literature—Giles<sup>8</sup> of Baltimore developed special staining and culturing methods to isolate toxic and non-toxic strains of the organisms and spores from street dust, and was successful in thus offering conclusive proof that clostridium tetani is widely distributed in street dust today. It would appear, therefore, that in hand injuries, in auto accidents, et cetera, prophylactic serum is usually indicated.

A tetanus toxoid is being developed which if found to be as effective as diphtheria toxoid will be a distinct boon to medics called upon to treat patients who are exposed frequently to tetanus.

### Preoperative Treatment

*Local Anesthesia.* — In many severe wounds, pain is a harmful and unnecessary factor, and the judicious use of local anesthesia is helpful. The lack of knowledge of the anatomy of the part to be anesthetized, or in its technic of administration should not be logical excuses for failure to use it.

DeTakats<sup>3</sup> enumerates but four contraindications to local anesthesia: (a) children under fourteen years of age, and certain nervous, irritable or mentally disabled patients; however, this group may be reduced by tact and proper pre-medication; (b) inflamed tissue never should be injected, "there is no objection, however, in performing distant nerve blocks for local inflammatory conditions"; (c) in cases of generalized infection; (d) in large complicated or radical operations. It might be noted here that Adam,<sup>1</sup> Professor of Surgery at the University of Budapest, reports over thirty-one thousand operations done under local anesthesia with no fatalities. He even does not hesitate in certain cases to infiltrate into inflamed tissue, very slowly, with a very fine needle.

Preoperative hypodermics of morphine, or the use of some of the barbiturates, are proper preliminaries to formidable operations, and anesthesia. One-half to 2 per cent anesthetic solutions may be used, depending on the character of the field, and type of surgery to be done. A warning should be sounded here in regard to the use of epinephrine in the anesthetic solution. It is a valuable adjunct because of the reduction of bleeding and prolongation of anesthetic effect, but it should not be used in



too great a concentration, a 1:200,000 preparation is strong enough. Regardless of the type of anesthetic used, needles should be of fine gauge, sharp, and long enough so that they do not have to be injected to the hilt to reach where required.

Here it must be emphasized that the patient should be lying down. Farr<sup>7</sup> states, "so-called 'idiosyncrasies' to novocaine, while extremely rare, probably do exist, and as patients not infrequently faint from other causes, which produce cerebral anemia—the treatment of both conditions demands the prone or inverted position." This procedure, when made part of the regular routine in the care of wounds, also enables the surgeon to seat himself and proceed with less effort and without a stiff back. The injured hand may be put at rest on a supporting stand or table.

To anesthetize the distal or middle phalanges, an endermic ring of injections about the base of the finger, beginning at the dorsum, should be followed by blocking of both dorsal and palmar pairs of digital nerves on each side of the bone.

When the metacarpo-phalangeal joint is to be attacked, begin the line of endermic infiltrations on the dorsum of the hand, an inch or more proximal to the joint; diverge the lines of infiltration to the webs of the finger and continue palmarward to converge them so they will meet at palmar point opposite the beginning dorsal point. Now, the nerves may be blocked by passing the needle proximally from the dorsum on each side of the metacarpal down through the web and parallel to the nerves which lie deep and near the bone.

In more extensive operations on the hand, the other fingers may be anesthetized individually or the nerves at the wrist may be blocked—a circular line of infiltrations is directed around the wrist  $\frac{1}{2}$  inch or more proximal to the radial and ulnar styloids, and through this nerves supplying the region are blocked deeply and individually. It should not be forgotten that there are four main trunks here: the radial, median, superior branch of the ulnar, and the dorsal cutaneous branch of the ulnar.

### Treatment

In turning to the actual care of wounds, one can do no better than to quote verbatim from Kock,<sup>9</sup> who has beautifully summarized their logical treatment into a few well

moulded rules: "(1) the first law of surgery; nihil nocere—to do no harm; (2) not to leave contaminated tissue in the injured area; (3) to avoid, so far as possible, leaving foreign bodies buried in the tissues; (4) to close every open wound as soon as it can be done with safety; (5) to put injured tissues at rest."

The picture also can be simplified and yet be made complete by classifying the many different kinds of injuries that may occur to a hand into two main groups—the contused or crushing injuries; and the non-crushing types. It is true that there will be some overlapping, and that one must exercise his best judgment of individual cases as they occur, but the treatment is fundamentally and vitally different, and the results obtained will depend on one's observing into which group the wound falls. Fractures and burns will not be dealt with, as they do not come within the scope of this paper.

*Crushing Wounds.* — Crushing injuries may well be discussed first, for their careful treatment not only brings gratifying results, but makes the surgeon a steadfast friend with his patient. These injuries usually are very painful, especially if one forgets that secondary swelling and tension will usually occur. Many times it is good treatment here to make incisions which will prevent this swelling, thus insuring better venous return, and often eliminating the danger of gangrene. One should not use tension here; it is far better at times to delay a neat surgical repair than to have the extremity become necrotic and a candidate for amputation.

A considerable amount of dirt may be washed from the wound by copious warm saline irrigations. Many hopelessly appearing fingers and hands can be saved by careful debridement, restoring bony alignment, and covering them together with the nerves and tendons with well-cleansed tissues loosely approximated, or not approximated by sutures as the condition may require, to avoid tension.

Silk, dermal, or fine alloy steel wire are far better than either chromic or plain catgut if one feels the necessity for placing sutures in crushing types of wounds. Some interesting studies by Babcock<sup>2</sup> have definitely proven the fact that in skin suturing, chromic and plain catgut are very irritating, especially to damaged tissues.

It is well, here, to remember that gas-

bacilli act on necrotic tissues—all the more reason to give the part every chance to recover, where circulation is intact enough to come back, by not shutting off an already damaged blood supply.

After such a wound is carefully prepared, it should be placed at rest by splinting and the dressings should be large, warm, and moist. The writer prefers either a solution of 20 per cent alcohol in saturated boric acid solution, or 20 per cent alcohol in saturated magnesium sulphate solution, for two or three days. This usually provides for rest in the tissues, and comfort from the pain of swelling and motion.

One should quite frequently have roentgenograms made of crushing injuries. It is many times discovered that even in the more minor appearing bruises of the fingers and hand that a comminuted fracture is present. This, of course, adds to the problem of splinting and after-care, particularly should the fracture extend into a joint. Disability from this type of injury is persistent and it would be very disconcerting not to find the fracture until after the injury had passed the usual time for complete healing.

At this point, before taking up the second main group of hand injuries, a few words in general concerning amputations are in order. Of course, this operation often becomes necessary in the non-crushing as well as the crushing group of wounds.

Amputations should be done quickly and with as little damage to the tissues as possible. One should always remember that *the prime factor is to give the patient a functional stump*. If circumstances prevent the formation of anterior flaps, which are usually considered the best in finger operations, posterior or lateral flaps may well be used. It is not wise to sacrifice more healthy tissue than necessary. Excellent results are often obtained by careful planning with what tissues are available. These facts are particularly important in cases of men who do heavy work with their hands. A strong, well-padded stump is better than none at all, particularly in cases of the thumb.

*Do not suture amputation flaps tightly;* they should be amply loose enough to account for swelling which follows the operation. A tight or even firm line of sutures will slough in nine out of ten cases and cause embarrassment to the surgeon, and pain for the patient.

Among many other points of consequence

in this operation it is well to ligate bleeding vessels and cut tendon ends clean. Painful and sensitive stumps may be avoided by using care not to pinch small nerve trunks in the line of sutures. By tapering the ends of phalanges, better appearing and more useful digits will be obtained, especially when just the distal phalanx has to be removed.

*Non-crushing Wounds.* — In attacking what may be elected to be called the non-crushing group of injuries, it may be well here to remark that care in treating minor wounds is important. Much can be done to keep simple lacerations from becoming complicated by proper preliminary cleansing of the area and by protecting it with a sterile dressing until healing is complete.

The actual preparation of the more severe non-crushing wounds should be done with considerable thoroughness. One may prepare as much of the surrounding field as possible while the anesthesia is taking effect, with the wound itself protected by sterile gauze. Sterile gloves may be used for this procedure, and plenty of green soap, and water, together with the use of benzine, or ether if much grease is present. Shaving the hair will help to convert the field into a clean place to work. The gauze covering the wound is finally removed and gentle, meticulous washing of the wound itself with sterile saline is carried out. Much of the dirt and loose dead tissue will be thereby removed. Bleeding is usually started anew, but this cannot be helped. The wound is now draped, gloves are changed, and if necessary, deeper pockets beneath torn flaps may be recleansed. Careful debridement of the dead and devitalized tissue is done during the sterile saline irrigation process, until the area presents healthy bleeding tissue. *Care must be used to preserve all tissues that have any possible chance to live.* No strong antiseptics need be used in most of these wounds if the above procedures have been carefully completed. In smaller wounds, 70 per cent alcohol is sometimes used or some of the milder antiseptics, never tincture of iodine.

This clean wound may now be repaired, and as Koch<sup>10</sup> says, convert a "compound injury into a simple one," for "if one is satisfied that cleansing has been accomplished, it seems quite as illogical to leave it open for an indefinite period as it does to leave a



herniotomy wound open after repair of the defect in the muscles and fascia." Of course, if the primary wound is too dirty, and one is not certain that contamination is satisfactorily removed, it may always be packed lightly with petrolatum gauze or gauze impregnated with a light antiseptic oily preparation. If no infection has occurred in 24 hours, the closure may be done, and the wound will heal by primary union.

Certain types of wounds of the hand demand special consideration — for instance, when tendons over large areas are exposed, such as may happen to the back of the hand, primary closure should be attempted to protect the tendons and insure better functional results. This procedure should be carried out even if full thickness grafts have to be resorted to, to cover the defects. One does not have to wait in these cases to get surprisingly good results. Scarring and adhesions do not seem to form under the full thickness graft, if care and primary consideration has been thorough. Fine silk sutures seem to give best results in this type of work. The grafts should be handled very delicately. Soft sterile gauze with Balsam of Peru or sterile paraffin mesh covered with soft gauze dressings will prevent sticking to suture lines. Adequate splinting and support with avoidance of early dressing changes should be strictly adhered to.

A few important points concerning the repair of tendons should be noted here. With the part anesthetized locally, the patient may aid by voluntary movements in reassuring the operator that he has the ends of the right tendons approximated, particularly in cases where two or more are severed in adjacent areas. One should remember the anatomy when searching for ends of severed tendons; they are many times right near together, especially in fingers, when the hand is in a relaxed position. Sometimes, of course, they retract two or three inches in the hand, and it becomes necessary to force them gently into the field by spirally wrapping soft rubber tubing from a point just distal to the elbow toward the wrist. If the whole hand is carefully scrubbed and surgically prepared so that it may be left open during the operation, the procedure will be greatly facilitated. The severed tendon ends should always be trimmed so that the approximation takes place between two fresh surfaces. Fine silk is strong and well tolerated by the tissues;

however, fine chromic may be used—either one is preferable to linen because they are better tolerated by the tissues. As to the method of approximation, one should be guided by the amount and condition of the tendon surfaces present.

In finger injuries where tendons are severed on both flexor and extensor surfaces, together with comminution of bones into joints, and with much tissue destruction, amputation is often advisable rather than subjecting the patient to the chance of a long convalescence and concurrent infection with resulting deformity.

Wounds over joints, no matter how small, if deep enough to require even one suture should be so handled. This insures closure and protects the joint against future arthritis. Strapping and other dressings usually will not hold the wound edges together.

Skin clips are a speedy and valuable part of wound repairing equipment, but they are best not used on palmar surfaces or over joints in larger wounds, particularly in workmen who are going immediately back to work, as they are too irritating under these conditions.

### Postoperative Care

*Dressings.*—As to dressings, the chief maxim should be comfort and adequate protection of the wound until healing is complete. This is particularly true concerning industrial workers, for there is nothing more disturbing than to have a patient say that the dressing didn't stay in place more than an hour after leaving the office. A light, soft, sterile gauze covering over the wound with Balsam of Peru to prevent sticking serves very well on freshly sutured cases. Adequate bandaging, splinting, and support—carrying the part in a sling, will help the patient to much comfort, and prevent after-pain and swelling following the operation even though of minor nature. It will also guard the part against injury, and give added assurance that the patient will not be too ready to put the extremity into active use.

*Records.*—One should keep complete records in all types of traumatic surgery cases, particularly where compensation may be involved. The history should be complete: the patient's name, age, and status; time and cause of accident; employment record; time, place and type of treatment; accurate diag-

nosis; and the amount of time disabled, if any. These facts go to make up a valuable and worth-while record.

A further note concerning x-ray may save embarrassing complications in the future. Films should be made when there is even the slightest evidence of fracture or metal foreign body, also when there has been loss of bony structure following amputations. This is often of important medico-legal significance.

As a closing word, it may be well to mention that further valuable records of traumatic surgery are to be had in dated and identified photographs taken before and after treatment—especially in some of the more severe injuries involving the loss of phalanges, severed tendons, and other types

of accidents which may be later contested in court. The protection such evidence accords is only exceeded by the satisfaction and pleasure derived from doing a complete and thorough job in the handling of the case.

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## GLUCOSE TOLERANCE AND PHOSPHORUS CURVES IN PATIENTS WITH DERMATOSES\*

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The rôle played by changes in sugar metabolism in the production of skin lesions has given rise to a considerable literature. The increase in accuracy of the methods for determining blood sugars, as developed by Folin and Wu, has stimulated these studies. As the laboratory technic has improved, the older work has become obsolete and it is necessary to consider only that done in recent years. McGlasson,<sup>5</sup> in 1923, showed that there was an association between hyperglycemia and the eczemas, and Ayers,<sup>1</sup> in 1925, also found a relationship between an impaired tolerance for sugar and eczema. Both of these observers felt that they were able to demonstrate clinical improvement in their patients when carbohydrate in the diet was limited. Greenwood studied a group of diabetics in 1927 and reported a higher incidence of follicular infections, and other dermatoses, than in non-diabetics. On the other hand Tauber,<sup>11</sup> in 1933, studied 511 cases with dermatoses and reached the conclusion that there was not only no increase in the blood sugar in these cases, but that there was actually a decrease, and on the basis of his observations recommended glucose as a proper form of treatment for furunculosis and the pyodermias. Somerford,<sup>9</sup> in 1933, reached the conclusion that there was an increase in the blood sugar in some dermatoses, especially eczemas, but, instead of this being the cause of the eruption, it was the result of it, the

inflammatory products of the skin causing the increase. Schamberg and Brown<sup>8</sup> studied twenty-five cases of acne intensively and reported the blood sugar as normal, stating specifically that they had not found the hyperglycemia that others had reported. Strickler and Adams,<sup>10</sup> in 1932, studied the fasting blood sugar in acne and found only 10 per cent above 110 mg. Greenbaum,<sup>3</sup> who studied the glucose tolerance curves in acne, was unable to decide from his data whether the acne was related to a disturbed glucose metabolism or not. In these reports different methods were used to determine glucose tolerance but in all cases the sugar was given by mouth. In some cases the simple fasting blood sugar was taken and there was no agreement as to what constituted a normal blood sugar. In 1933, Rost<sup>7</sup> did a very accurate piece of work in which glucose tolerance curves were studied that had

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been produced by the intravenous injection of the glucose. He found no correlation between dermatoses and hyperglycemia except in certain eczemas. In 1936, Crawford and Swartz<sup>2</sup> hospitalized ten patients with acne and studied them carefully, doing glucose tolerance tests with intravenous injection of the glucose. They found no increase in the blood sugar and treated their patients with glucose by mouth and intravenously. And finally in May of this year Pillsbury and Sternberg<sup>6</sup> published their results showing that, in dogs, experimental infection of the skin is more severe in animals on a high carbohydrate diet.

Because of the conflicting and confusing evidence presented by this literature, we determined to study our own clinical material in an effort to crystallize our opinion in the matter. We, therefore, selected for study 150 consecutive cases with various dermatoses who had had glucose tolerance tests done. We tried to answer two questions: (1) Is the glucose tolerance disturbed in this group of patients, and (2) if such a disturbance is present, can a successful therapeutic program be based upon this fact?

### Method

The method used in determining the glucose tolerance curves was that devised by Hartman and Foster.<sup>4</sup> The first specimen for the curve was the blood from the fasting patient. Thirty-five grams of glucose was given intravenously in 50 per cent solution over a period of five minutes. Specimens of blood were then taken at intervals of 15, 45, 75, and 150 minutes. Blood sugar determinations were performed by the method of Folin and Wu, and the inorganic blood phosphates were determined by the method of Benedict and Theis. Various values have been given for a normal blood sugar but the values used here are from 75 mg. to 100 mg. of glucose per 100 c.c. of blood. It has been determined that by this method the second specimen of blood taken 45 minutes after the intravenous injection of the glucose was started, should not exceed 120 mg. of glucose per 100 c.c. of blood, in persons of average weight. Anything above this is interpreted as a decreased tolerance. In this study utilization has been made of the blood phosphate curve. This curve has been shown experimentally in dogs to be related to the production of in-

sulin. It has been found that following the entrance of glucose into the blood the amount of inorganic phosphates decreases. As the glucose is acted upon by the insulin the inorganic phosphates in the blood decrease. At the end of the test, the amount of inorganic phosphates should have shown a recovery to approximately the fasting level. This is interpreted as showing a reciprocal relationship between the inorganic phosphates of the blood and the insulin action. A lack of recovery of the phosphate curve is interpreted as showing an insulin lack. This fact has been an aid in determining whether a given individual shall receive insulin.

In this group of 150 patients the dermatological diagnoses were as follows:

Acne vulgaris .....	76
Furunculosis .....	34
Eczema (mostly of the neurodermatitis type)...	23
Miscellaneous .....	17

This group did not include any patient with frank diabetes mellitus.

### Acne Vulgaris

Of the 150 patients studied, seventy-six had a diagnosis of acne vulgaris. This group of patients, in general, were those who had not responded to ordinary forms of therapy, including in most cases x-ray. It was found that in this group there were significant changes in the glucose metabolism and that in addition, there were other metabolic changes of importance best demonstrated by the basal metabolic rate determination.

TABLE I.

Acne Vulgaris—Total.....	76
Number showing decreased tolerance.....	53 (70%)
Number showing normal tolerance .....	23 (30%)
Total number of patients having BMR....	34
Number patients with minus BMR.....	22 (65%)
Number patients with normal BMR.....	12 (35%)

An analysis of this group is shown in Table I. Seventy per cent of the cases with acne vulgaris showed a definite disturbance in their glucose metabolism. Both the blood sugar curves and the blood phosphate curves were considered in deciding whether the glucose metabolism was normal or not. In 17 per cent of these cases the blood phosphate curve was of value in determining the metabolic error. It is important to note that in this study those cases with extreme changes in glucose metabolism are not being

considered. Definite changes, though moderate in degree, are of importance.

Of the thirty-four patients in whom the basal metabolic rate was determined, 65 per cent showed the rate decreased. In the group showing a decreased basal metabolic rate, 70 per cent also showed a decreased glucose tolerance.

TABLE II.

Number over 20 years of age .....	49
Number under 20 years of age .....	27
Percent with decreased glucose tolerance:	
Over 20 years .....	78%
Under 20 years .....	55%
Percent with low BMR:	
Over 20 years .....	60%
Under 20 years .....	73%

It has long been recognized that the most difficult group of patients with acne to influence favorably with treatment is the group who have passed adolescence. We have chosen the age of twenty years as the dividing line. In the earlier age group improvement, or at times cure, may be expected with the passage of a few years, even without treatment. In the older group the problem is more difficult. One of the points of interest in this study was a possible explanation of this fact. Table II shows that of the seventy-six patients twenty-seven were under twenty years of age and forty-nine were above. Seventy-eight per cent of the older group showed a decreased tolerance for glucose as contrasted to 55 per cent for the younger. When it is realized that on an average there were but a few years difference in the ages of the two groups this trend is of importance. The group with the error in the glucose metabolism was the group that did not clear up at the usual period. The figures for the basal metabolic rate were not so useful. Here 73 per cent of the younger group show a decreased basal metabolic rate, as compared to 60 per cent for the older group. This may be explained in part by the fact that not all of these patients had basal metabolic rates determined and in the younger group only those who were obviously low were tested.

#### Treatment

In the study of the results of treatment in this group of patients with acne vulgaris our chief concern was to determine the effects of the administration of insulin and thyroid. It must be kept in mind that all of these patients were first given thorough

general treatment for acne. This consisted of moderate restriction in carbohydrates, that is candy, pastry, et cetera, local hygiene of the face (thorough washing, avoidance of trauma and the application of a sulphur lotion), relief of constipation, treatment of any seborrhea present, and the use of vaccines, x-ray, and ultraviolet light where indicated. In addition to this, part of the group was given insulin or thyroid or both. We wish to contrast the response to treatment in the group receiving only general treatment with the group receiving, in addition to general treatment, insulin or thyroid or both.

It can usually be claimed with justice that estimates made as to progress, in the chronic dermatoses under treatment, are too optimistic. In this study, however, one group of treated cases is compared with another group being treated simultaneously and the factor of optimism is as strong in one group as in the other. Insulin was given only to patients with decreased glucose tolerance and thyroid only to patients with low basal metabolic rates.

TABLE III.

Treatment—Acne—76 patients.	
Treated with general measures and insulin or thyroid or both .....	50
Improved .....	78%
Unimproved .....	22%
Treated with general measures only .....	26
Improved .....	51%
Unimproved .....	49%

In this group of seventy-six patients with acne (Table III), fifty were given, in addition to general treatment, insulin or thyroid or both. Of these fifty patients, 78 per cent were improved and 22 per cent were unimproved. Again, in this group of seventy-six patients, twenty-six received general treatment only. In this group 51 per cent were improved and 49 per cent were unimproved.

TABLE IV.

Treatment—Over 20 years—49 patients	
General measures and insulin or thyroid or both .....	38
Improved .....	70%
Unimproved .....	30%
Treated with general measures .....	11
Improved .....	45%
Unimproved .....	55%

Again dividing this acne group into those over and those under twenty years of age, we find that in the older group (Table IV), there were forty-nine patients, thirty-eight



of whom received general treatment with the addition of insulin or thyroid or both. Of these 70 per cent were improved and 30 per cent were unimproved. Eleven received



Fig. 1.

only general treatment and of these 45 per cent improved and 55 per cent were unimproved. In the group under twenty years (Table V), there were twenty-seven patients. Of these twelve received combined treatment, 83 per cent being improved and 17 per cent unimproved. Fifteen patients received general treatment only. In this group 67 per cent were improved and 33 per cent were unimproved. The relatively good showing for the younger group treated with general measures only would suggest that the endocrine factor was less important in the younger group than in the older one.

TABLE V.

Treatment—Under 20 years—27 patients	
General measures and insulin and thyroid or both .....	
Improved .....	12
Unimproved .....	83%
Treated with general measures only.....	15
Improved .....	67%
Unimproved .....	33%

One more analysis seems worth while. There were fifty-three patients with acne who had a decreased tolerance for glucose. Forty-one of these patients received general treatment and insulin or thyroid or both, and twelve received only general treatment. The group receiving combined treatment showed improvement in 76 per cent of the cases, while in the group getting general treatment, only 45 per cent improved.

#### Furunculosis

The scope of this paper does not permit of a detailed analysis of the remaining groups. There were thirty-four patients with recurrent furunculosis. *Ninety-one per cent* showed a decreased tolerance for glu-

cose. Of the thirty-four patients, one-half, or seventeen, received combined treatment. In the group given combined treatment 82 per cent were improved as against 41 per cent improved in the group receiving only general treatment. Thyroid was of less value in this group than in the group with acne.

#### Eczema

There were twenty-three patients with eczema, for the most part neurodermatitis of the diffuse type. Eighty-seven per cent of this group showed a decreased glucose tolerance. Here only 50 per cent of those receiving insulin and thyroid in addition to other treatment, showed improvement, as contrasted to 60 per cent of those not receiving insulin and thyroid. This is not surprising as the most difficult cases were given endocrine therapy. Thyroid and insulin were of distinct benefit in selected members of this group. Here thyroid was of more importance than in the other groups. Many of these patients were allergic.

#### Miscellaneous Group

There were seventeen patients in this group and the diagnoses were as follows:

Alopecia areata .....	7
Pruritus .....	6
Dermatitis herpetiformis .....	1
Recurrent erysipelas .....	1
Onychiauxis .....	1
Necrobiosis lipoidica diabeticorum.....	1

In this group 64 per cent were found to have decreased tolerance for glucose. No attempt will be made to summarize the results of treatment except to note that thyroid and insulin seemed to be of value in certain cases of pruritus and of alopecia areata.

I wish, however, to report briefly the case of necrobiosis lipoidica diabeticorum.

This patient was a man, sixty-eight years old, with arteriosclerosis, who in early March had been badly bitten by what he described as "sand flies," while playing golf in Florida. The sites of these bites developed a persistent pruritus that lasted for over two months. On June 14, 1937, three and a half months after the episode of the insect bites, he was seen with three small lesions that had developed on the lower legs, at the sites shown in the photograph (Fig. 1). The skin was dry and pruritic, the eyebrows thin. The lesions when first seen were circinate and from 1 to 1.5 cm. in diameter. They were slightly raised and the borders were sharp; the surrounding skin showed no inflammatory reaction. The lesions were firm with a soft infiltration, rather than induration, dark red in color but becoming yellow under pressure. As the lesions advanced the yellow color became more prominent. The surface epithelium desquamated freely in large, flat thin scales. There was no weeping or ulceration.

There were no subjective symptoms. A bland ointment would remove all scale and the surface was then smooth and glistening with a waxy appearance. They increased rapidly in size, the largest becoming 6.5 by 7 cm. in a little less than two months.

Metabolic studies showed the urine sugar-free. The glucose tolerance curve showed a marked decrease and the blood phosphate curve showed insulin lack. The blood cholesterol was 210 mg., the normal value being 140 to 160 mg. The basal metabolic rate was minus 10 per cent.

It was felt that the high blood cholesterol was associated with the potential diabetes and the lowered basal rate. The patient was given a diet with 200 grams of carbohydrate, and started on  $\frac{1}{2}$  grain of thyroid. By July 13, 1937, the blood cholesterol was 140 mg. and the basal metabolic rate was minus 2 per cent. The lesions stopped increasing in size and they now appeared to be undergoing involution. The yellow color was fading and the plaques were becoming thinner. More time and further study are necessary in this case but the suggested relationship between the lowered metabolic rate and the disturbance in the glucose and lipid metabolism is interesting.

### Conclusion

In conclusion, it has been shown that there is a significant decrease in the glucose tolerance, in a considerable majority of the patients studied. It has also been shown that a complete study of these patients is necessary and that any disturbance of the endocrine system may be of importance and that the basal metabolic rate determination in addition to a glucose tolerance test is a useful method of investigating these changes. We believe that treatment based on these findings has proved to be of distinct value. We do not believe that the various percentages of improvement are to be taken literally, and probably would not be exactly duplicated in another similar group, but we do believe that these figures represent definite trends, and that these trends would be found in another similar group of patients. We agree with Strickler and Adams<sup>10</sup> that the fasting blood sugar is of little value in these studies, only one case in this series showing a fasting blood sugar of more than 100 mg. and that one was only 110 mg. We further believe that

the therapeutic results shown in this study support the thesis that the moderate decrease in glucose tolerance demonstrated in these patients by this method is an actual disturbance in glucose metabolism and that it is of importance clinically.

### Summary

1. One hundred fifty patients with dermatoses, who had had glucose tolerance curves determined, were studied.

2. The method used for determining glucose tolerance is described.

3. Seventy per cent of the cases with acne vulgaris showed a decreased tolerance for glucose and the other dermatoses gave comparable results.

4. The basal metabolic rate was found to be an important factor.

5. Better results were obtained in treatment in the group given insulin and thyroid, where indicated, than in a control group where these were not used.

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# MENTAL HYGIENE AND EPILEPSY

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## FOREWORD

This article by Dr. R. L. Dixon has the sponsorship of the Committee on Mental Hygiene of the Michigan State Medical Society and is heartily recommended to the profession. The profession full well is aware of some known organic causes of that form of mental illness whose symptomatic picture is, for the want of a better name, termed epilepsy. Dr. Dixon very clearly shows some of the suggestive characteristics that may later develop into frank epileptiform episodes. The prevention of mental illness, as with tuberculosis, lies in early recognition and treatment.—EDITOR.

If we are to consider mental hygiene in relation to epilepsy, it is obvious that we must justify the placement of epilepsy in that group of mental and emotional disorders to which preventive measures may be applied. To do so necessitates the elimination of the group in which the convulsion is merely a symptom of an organic brain disease or defect, and the restriction of our discussion to idiopathic epilepsy.

We use the term idiopathic in a specific relation, not solely for classifying into one general category all of those cases for which we can find no other cause, but as an alternate for constitutional or genuine epilepsy which is accepted by many authorities as a disease entity. The convulsive phenomena, in this instance, are reactions to a difficult life situation on the part of certain individuals who manifest definite personality deviations apart from and prior to the onset of the convulsion proper.

There is much to be done in the determination of a definite pattern of behavior that the parent, teacher or physician may come to apply to maladjusted children as diagnostic material if we would recognize and treat our subjects during these pre-convulsive stages. That end can be attained in no better way than by stimulating in the persons most intimate with the problems of childhood a curiosity that will make them alert to those already recognized traits that we find ourselves combining into the expression "a typical epileptic personality."

Just what underlies this failure on the part of certain organisms to meet the requirements of daily life is still unknown, but the histories of confirmed epileptics reveal the fact that the abnormal reactions, of which the seizure is but one, manifest themselves at a very early age and set that child apart from his normal siblings in the parents' minds.

One of the earliest and most generally recognized deviations is the temper tantrum. The child who flings himself on the floor, bumps his head, kicks and screams to a degree out of all proportion to the situation, is showing evidence of an unacceptable behavior pattern that calls for prompt and thoughtful attention. It is not enough to say that when he reaches the age of reason he will realize that it isn't the proper thing to do. Long before language has meaning to him, habits are forming and guidance is effective. The program must be so formulated as to minimize the situations which bring about these responses, but it cannot be supposed that this child can always have someone preceding him through life and smoothing his way. He must learn through pleasant and unpleasant associations that one's ends cannot be gained by displays of this sort. He must be trained to meet and adjust to the unavoidable in a way that will bring the utmost satisfaction.

Other evidences of inadequate control are nail biting, thumb sucking and persistent enuresis. We will not go into a discussion of the various types of treatment proposed for handling these problems, but stress the fact that they do appear to occur with more than normal frequency in the epileptics' histories and serve as unfavorable signs to which we must likewise be alert.

Social conflicts based on aggressiveness, selfishness and egocentricity, destructiveness and irritability, tend to aggravate the child's situation and lead to an ever-increasing need for avoidance and compensatory reactions on his part. These characteristics, it must be stressed, occur very frequently before the convulsive period and are common enough to be thought of as specific components of the epileptic personality.

Aggressiveness, in particular, expresses itself in such examples as the child who repeatedly waves his hand for the teach-

er's attention in order that he may recite, whether he knows his subject or not; the one who has no respect for adult judgment and authority and forces his way into groups in which he has no rightful place; and the one who is determined to dictate to the play group even though he lacks the desirable qualities of leadership.

Selfishness and egocentricity require no exemplification, but are, nevertheless, manifested in characteristic fashion in this particular type of child. He indulges in persistent demands for the mother's care and attention; makes no compromises with his playmates; builds his entire environment around himself and feels that there should be no question but that he and his wants should have primary consideration.

The irritability is shown in all of his relationships as an over-active, high-tempered, restless and excitable child.

Destructiveness may be expressed in the simplest forms of play, with toys and dolls as the first victims, and the tendency becomes more and more evidenced as the child grows and his environment extends beyond the crib and nursery.

Here again, as with the tantrum, both the stimulus and the response require alteration; they must be in accordance with a program adapted specifically to this consti-

tutionally inadequate mechanism. Innumerable other abnormal traits appear in the literature relative to the epileptic and all add weight to the notion that we are dealing with an emotional problem that must be treated in its entirety. We must not wait for the final outbreak, the complete withdrawal which the convulsion expresses. The seizure is alarming and arouses in the parent a frenzied desire to suppress this unnatural manifestation, but the suppression of the symptom will not cure the disease. It is a total life reaction and early recognition of the varied other symptoms is essential if we would avoid the disastrous course that lies ahead of the confirmed, *convulsive* epileptic.

It is, therefore, to the mental hygienist that we must look for the competent supervision needed in the shaping and guiding of the lives of pre-epileptic children. The adjustment must extend into all phases of the individual's environment, and it can be only through the combined efforts of all who come in contact with the child that we can hope for progress. It remains for mental hygiene to determine the course of treatment, educate the various persons involved in the program, and to coördinate the child's activities and relationships in such a way as to bring him into harmony with his surroundings.

### Acute Appendicitis in Children

Philip D. Allen, New York (*Journal American Medical Association*, July 10, 1937), bases his study of acute appendicitis in childhood on 612 cases treated in the Children's Surgical Service at Bellevue Hospital for the ten-year period from 1926 to 1935 inclusive. It is made as a sequel to Beekman's report of 145 cases taken from the same service at an earlier date. It includes all children up to the age of 13 years. The study emphasizes the old and oft repeated observation that, to reduce the mortality of acute appendicitis, operation must be performed soon after the onset of symptoms. It shows that prolonged illness before operation increases mortality and morbidity and prolongs hospitalization. The high death rate from spreading peritonitis in the young infant makes early operation especially imperative in this group. The mortality rate of 15.2 per cent in infants compares favorably with the mortality rate of 25.6 per cent noted in Beekman's 1924 report. While this would tend to show that patients were being brought to the hospital earlier and perhaps that present treatment is more efficient, the mortality could be reduced further by still earlier operation in this group of children. Children more than 5 and adults suffering from appendicitis seem to present essentially the same history and physical manifestations. It is the younger group that calls for special attention. While vomiting may

be given as the first symptom, it is likely that in most cases the child had been previously suffering from pain. The frequent use of cathartics administered by the mother and all too frequently by the family physician undoubtedly increases and hastens the progress of the disease. The infant's lack of resistance to infection and the lack of sufficient omentum to wall off the process makes early operation necessary if one is going to prevent spreading peritonitis with its high mortality. The procedure whereby only the peritoneum is sutured in cases in which it is apparent that drainage is going to be profuse should be especially emphasized. The incidence of hernia is lower in this group. The two most common objections are, first danger of disruption and, second, wide ugly scars. Neither is a valid argument. The high percentage of infections in wounds closed without drainage in this series is to be deplored. It is accepted that the peritoneum will withstand greater contamination than the abdominal wall. It is also true that the abdominal wall of children is less resistant to contamination than that of the adult. More extensive use of a small rubber dam drain down to the peritoneum in these borderline cases should prevent this frequent infection. These drains may be left for about forty-eight hours, thus providing egress for serum, a culture medium for bacteria. This procedure does not delay convalescence, as these wounds heal practically as if drainage had not been employed.



## CONTINUED FEVER: MENINGOCOCCEMIA\*

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There are certain diseases which, because of their nature, do not allow of ready diagnosis. This is particularly true of the more or less common fevers such as rheumatic, typhoid and paratyphoid, undulant, Rocky Mountain spotted and typhus, and of tularemia or trichiniasis. All of them are likely to result in a prolonged clinical course with long continued fever. Other less common conditions also fit into this category. In some instances a diagnosis is quite readily made but occasionally great difficulty is encountered. As a result the acumen of the clinician is often severely taxed and laboratory procedures or tests are exhausted in an attempt to arrive at the correct diagnosis—in some few instances the diagnosis remains undetermined. In March of 1937 a patient whose clinical condition proved a diagnostic problem was admitted to the Herman Kiefer Hospital.

### Case Report

A white man, aged twenty-five years, was sent into the Cincinnati-Louisville flood area as a truck driver and remained there for a period of five days, from January 8 to 12 inclusive. He returned to Detroit and became ill on February 13, complaining of backache, headache, and pain in the neck. He was first seen by a physician on February 16, at which time he complained of the same symptoms. A lumbar puncture was performed, and 1,000 cells were reported. Four hours after this procedure he was admitted to this hospital, where, on lumbar puncture, a clear fluid was delivered with a cell count of 2.

On admission the patient's condition did not appear critical. Examination of the skin showed a moderate number of light pink spots distributed over the body and extremities. The lesions were macular in character and varied between  $\frac{1}{2}$  and 1 centimeter in diameter. The nasopharynx was slightly injected. There was some resistance encountered on complete flexion of the neck on the chest. The patient was able to sit up but felt weak. Examination of the chest showed no abnormal findings. The heart sounds were of normal intensity, and the pulse was slow. Palpation of the abdomen elicited tenderness, especially in the upper left quadrant. The superficial and deep reflexes were normal. Palpation of extremity and trunk muscles caused pain. The temperature on admission was 99.2°, the pulse rate 88, the respiratory rate 20. The initial blood count showed the following: 4,330,000 red blood cells; 12,600 white blood cells, and 85 per cent hemoglobin; 79 per cent polymorphonuclears; 14 per cent lymphocytes; 3 per cent monocytes; 2 per cent eosinophiles; 1 per cent basophiles. Further tests of the spinal fluid obtained on initial puncture showed no globulin and a quantitative sugar determination of 87 mgms. per 100 ml. On the second day in hospital no new lesions could be observed. The patient was listless, and he complained of an aching sensation in the muscles and joints. On February 19, the temperature, which had been normal up to this time, rose to 102° at noon. Roentgen examination of the sinuses showed no pathology. The following tests were all negative: blood culture, blood and spinal fluid Kahn, stool examination for the presence of typhoid and paratyphoid organisms, agglutination tests for typhus and Rocky Mt. spotted fever, and

smears for malaria. A lumbar puncture performed on this date revealed a clear fluid with a cell count of 30, a differential count with lymphocytes predominating, and a quantitative sugar determination of 91 mgms. per 100 ml. On physical examination, the deep tendon reflexes were diminished. Cutaneous sensitivity was normal, but body musculature was tender on palpation. Complete flexion and extension of the extremities caused pain. On February 20 the temperature was normal for a twenty-four hour period. The patient felt somewhat better and complained less of body aches and pains. On the following day there was a rise in temperature to 100.4°, and during the succeeding week a temperature rise occurred every second or third day. Subsequent smears for malaria and blood taken for agglutination tests for Rickettsial infection proved negative.

On February 27, his twelfth day in the hospital, the patient complained of a general aching of the body which was especially noticeable in the back and legs. He was hypersensitive to palpation of muscle groups and winced especially on palpation of the calves of the legs. The blood count showed 3,610,000 red blood cells; 16,100 white blood cells, and 75 per cent hemoglobin; a differential count showed 78 per cent polymorphonuclears, 17 per cent lymphocytes, 4 per cent monocytes, 1 per cent myelocytes. The afternoon temperature was 102.4°, the pulse rate 100 and the respiratory rate 22. The following day the temperature subsided somewhat, but the stiffness and pain in the muscles of the neck were rather marked. He also complained of severe pain in the back and legs, and the position he assumed while lying in bed was an approximation to a knee-chest position while lying on his side. He did not care to be disturbed. On March 1, many small, pink-colored macules appeared on the body and extremities. This was a new group, for the original rash noted on admission had faded out. These lesions were variable in size, averaging between 1 and 4 millimeters and were painful to touch, especially those which were situated near joints. Difficulty in motion of extremities was noticeable and complained of. The temperature throughout the entire day was normal. A blood count taken at this time showed 11,000 leukocytes, 59 per cent polymorphonuclears, 34 per cent lymphocytes, 2 per cent monocytes, 3 per cent eosinophiles, and 1 per cent Turck's irregulars. Blood was taken for guinea-pig inoculation and for blood culture. A second Widal was reported as negative. On March 2, there was another rise in temperature, and later in the day the blood taken for culture on February 25 was reported as positive for meningococci Type III. Meningococcus antitoxin (Ferry) to the amount of 80,000 units was given the same afternoon following a serum sensitivity test. The following day the patient was given 40,000 units of meningococcus antitoxin. He appeared better; he stated that he felt much better; but the lesions were still present and painful to touch. This

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was less noticeable toward the evening of that day. On March 4, the lesions had faded out fairly well; the patient appeared much better; the temperature was normal; and no serum was given. A blood culture taken on this day was negative. On March 5, the patient again appeared listless and drowsy, and complained of stiffness of the legs. Numerous spots again appeared on the body and extremities. The afternoon temperature was 101.1°. The following day 40,000 units of meningococcus antitoxin were given by the intravenous route. Pain in the extremities was marked. There was slight neck stiffness and a new crop of lesions had appeared. The guinea-pig, which had been inoculated with blood taken from the patient on March 1, expired on the sixth of March, but on postmortem examination, meningococcus infection could not be determined. A peritonitis was present and streptococci were noted on direct smear. On March 7, 60 c.c. antimeningococcus serum were given by the intravenous route, and this procedure was followed by a severe chill with pain in the back and legs. There was a slight temperature rise noted in the afternoon, but on the following day no fever was present. The patient felt better; there were no new lesions, and the old ones were rapidly disappearing. He developed a moderately severe attack of serum sickness which first appeared late in the afternoon. This condition persisted for the next four days, and although the patient was inconvenienced by the itching attendant upon this affliction, the temperature was normal, and he felt very much better. During this interval all the lesions disappeared, and following it convalescence was uneventful, and the patient was dismissed on the twenty-ninth hospital day.

It is not often that one has the opportunity to follow a meningococcus septicemia for so long a period of time prior to institution of specific therapy. In this instance, the history of a trip into the flood area and the atypically colored lesions led us to suspect an out-of-the-ordinary infection. Meningococcus septicemia was considered, but with

repeated negative blood cultures this diagnosis could not be determined. The rash was not typical of petechiae seen in the course of epidemic meningitis, for generally the lesions are of a purplish hue. The lesions encountered in this patient were pale pink in color, and simulated the rose spots seen in typhoid fever. The occurrence of the lesions in crops with a temporary rise in temperature whenever they appeared, further served to make this diagnosis less plausible. Upon evidence by blood culture that we were dealing with a meningococcus infection, proper therapy was instituted. It was felt that this case was suitable for testing the efficacy of meningococcus antitoxin, for there was no evidence that the meninges were involved. Hoyne† has consistently emphasized the fact that in the treatment of meningococcus infections we have been prone to stress local treatment at the expense of therapy directed at the general infection. Here, then, was an opportunity to test its efficacy under ideal conditions. Although 120,000 units of antitoxin were used during a period of forty-eight hours, a recurrence of symptoms occurred on the fourth day following institution of therapy. There is a temptation to cease using a therapeutic agent whenever symptoms appear to be alleviated. In this instance, therapy might well have been continued for another day or two.

†Hoyne, A. L.: *Nebraska Med. Jour.*, 21:321, 1936.  
Hoyne, A. L.: *Jour. A.M.A.*, 107:478, 1936.

#### Pentobarbital-Sodium and Scopolamine Hydrobromide

During the three year period that ended Nov. 1, 1935, Charles Edwin Galloway, Robert M. Grier and Robert Blessing, Evanston, Ill., (*Journal A. M. A.*, Nov. 21, 1936), delivered 2,275 mothers and administered pentobarbital-sodium and scopolamine hydrobromide to 1,415, or 62 per cent. If a patient reaches the ward in rapid labor, gas is used both for analgesia and for anesthesia, and nitrous oxide for the former and thylene for the latter. The other contraindications for the use of pentobarbital-sodium and scopolamine hydrobromide are full stomach, infection of the upper respiratory tract, prematurity and heart disease. When the patient is in labor, regardless of the amount of dilatation of the cervix, she is given 7½ grains (0.5 Gm.), of pentobarbital-sodium in five separate capsules with a pin hole in each. The earlier it is administered the better. About five minutes later the patient is given half a drachm (2 Gm.) of sodium bicarbonate in water to help alkalize the stomach. When the pentobarbital-sodium is given, scopolamine hydrobromide, 1/150 grain (0.0004 Gm.), is administered by hypodermic injection. The patient should pass quickly through the excitement stage and then be kept there by an additional 1½ grain (0.1 Gm.) capsule of pentobarbital-sodium every two or three hours. This ad-

ditional amount is necessary because the drug is constantly oxidized in the body. Every patient has a special nurse assigned as soon as the pentobarbital-sodium and scopolamine hydrobromide are given, and the nurse must not leave the bedside until about five hours after delivery. If the patient becomes restless not only with the pain but also between pains and if her restlessness seems extreme, a little more pentobarbital-sodium may be administered, but never more than 3 grains (0.2 Gm.) additional Morphine and other narcotics should never be administered to such patients until after the third stage of labor. When the patient is ready for delivery she is given ethylene, put to sleep, prepared, draped and delivered. Outlet forceps and episiotomy is the choice procedure for delivery, 20 per cent being spontaneous, with the usual small number of breech and other operations. In this series of 1,415 deliveries for which pentobarbitau-sodium was given there was a maternal mortality of 0.7 per cent, a gross fetal mortality of 2.19 per cent, an obstetric fetal mortality of 0.64 per cent and a maternal morbidity rate of 5.08 per cent. Maternal mortality and morbidity are not increased. Infant mortality is not increased. Fetal morbidity is increased if one considers the somnolence, flaccidity and bradycardia produced in the infant. This condition, however, has not led to an increase in fetal mortality.



# PRECANCEROUS LESIONS OF THE SKIN AND MUCOUS MEMBRANE\*

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Skin cancer inherently carries a better prognosis than mucous membrane cancers because many of the former are of the relatively benign basal cell type. Cancers of the internal organs such as the stomach, intestines, or bladder, are almost never diagnosed until late in the disease when symptoms of obstruction, changed function, or cachexia appear. Usually metastasis with its usual fatal result has already occurred. The prognosis in these cancers is and will be very poor until some means of early diagnosis can be devised.

The diagnosis of cancers of the mucous membrane easily examined from the exterior can and should be made in most cases in the early curable period when the lesion is purely a local matter. The prognosis for this reason, though not as favorable as skin cancer due to the higher grade of malignancy in mucous membrane lesions, should certainly be much more favorable than in the case of internal organ carcinomas.

Bruno Block<sup>1</sup> stated, "Deaths from cancer would be greatly reduced if all precancerous conditions were as easy to diagnose as those of the skin." Most dermatologists agree that treatment of the so-called precancerous lesions of the skin and mucous membrane before degeneration has taken place would greatly decrease the incidence of cancer and therefore improve the prognosis considerably.

The purpose of this paper is to bring again to the readers' minds those so-called precancerous lesions of the skin and mucous membrane which are prone to degenerate, and advocate their early adequate treatment. No attempt will be made to discuss the question raised by Sutton<sup>2</sup> and others as to whether these lesions are precancerous or cancer from the start.

## Group I

*Group I* includes conditions such as keratosis senilis, xeroderma pigmentosa, where a very high percentage of the lesions degenerate into cancer. Block<sup>1</sup> and others felt that all of these lesions would eventually lead to carcinoma if the patient lived long enough.

*Keratosis Senilis.*—The normal physiological aging of the skin which appears in different people at varying ages consists of

a generalized atrophy or thinning of the epidermis with loss of the secondary skin structures such as the hair and glands. This is frequently associated with a severe form of pruritus hiemalis or senile pruritus. Over the face, neck, backs of the hands and forearms or the areas exposed to the elements, pigmented macules and telangiectases appear. In many people, particularly sailors, farmers and others exposed to the elements year after year, many of the pigmented macules become raised pigmented keratoses. Approximately 5 per cent of these so-called senile keratoses degenerate into cancer. This is particularly true of those irritated or traumatized in one manner or another.

Usually those keratoses on the skin of the face degenerate into the less serious basal cell type of cancer while those on the hands, arms, neck, ears and mucous membrane of the lip or eyelids degenerate into the more serious prickle cell type which is prone to metastasize.

A softening salve such as 10 per cent oil of theobrome and 1 per cent salicylic acid in cold cream will be sufficient in the smaller nonirritated lesions if the patient is under observation. Any lesion which is large, growing, under chronic irritation, or ulcerated should be promptly treated with curette and cautery though it can also be adequately treated with radiation therapy.

## Precanceroses Caused by Chemicals

*Tar and Other Hydrocarbons with High Boiling Points.*—Gas work-stokers, creosote workers, benzine, tar and coal workers, pitch-handlers lampblack-workers, aniline dye-workers, chimney-sweepers, mule-spinners and others who work about tar and other hydrocarbons with high boiling points are very prone to develop

\*Read before the seventy-second annual meeting of the Michigan State Medical Society in Grand Rapids, September, 1937.

keratoses similar to senile keratoses on the part of the body exposed to the chemical. As most of these keratoses are found on the hands and arms most of them degenerate into the serious prickle cell type of cancer. The treatment of these precancerous keratoses is the same as that of the senile keratoses. Many cases can be eliminated by proper ventilation and improved methods of handling these chemicals in industry.

*Arsenical Keratoses.*—The sulphides of arsenic have been used in medicine since the beginning of the Christian era. In more recent years, due to its wide use in industry and the arts making it readily accessible to all, arsenic has been used extensively in homicide and suicide. Unintentional cases of chronic and acute arsenic poisoning have been more common of late years due to its use in medicines, dyes, preservatives, sprays, insecticides and as an impurity carried into various industrial processes via sulphuric acid.

The effect of arsenic on the skin offers a strange paradox. Small doses under the control of an expert dermatologist often lead to miraculous improvement and often temporary cure in such chronic diseases as sensitization dermatitis, Duhring's disease and psoriasis. Its indiscriminate use by the untrained physician, penny grabbing or uninformed druggist, the patent medicine industry, and even the laity quite often leads to serious changes in the skin.

The chronic intake of trivalent arsenic and rarely the pentavalent arsenic (i.e., arsphenamines) leads to changes in the skin as follows: in addition to the speckled trout pigmentation on the neck and trunk, pigmented macules and numerous keratoses appear on the palms and soles. These feel like a nutmeg grater on palpation.

These keratoses degenerate in time to form squamous cell cancers of rather high malignancy which unfortunately are prone to early metastasis.

The most vital point in treatment is prophylaxis. Here education of the physicians, druggists and laity regarding the dangers of its use in patent medicines and industry will help the most. The keratoses when they appear should be kept under observation. Any lesion that is chronically irritated or breaking down should be promptly curetted and cauterized.

*Xeroderma Pigmentosa.*—In this fortunately rather rare condition which runs in families there is apparently an inherited susceptibility or predisposition to the effect of certain rays of the spectrum. Beginning usually early in life the skin exposed to light rapidly takes on the characteristics of the senile skin. Atrophy, pigmentation, telangiectases and keratoses appear. They appear more rapidly in the summer months. These changes may appear in a few weeks in the severe case or be delayed to early adult life in the milder case. These keratoses are true precancerous lesions and many degenerate in time into squamous and basal cell carcinomas.

A very severe photophobia with excessive lacrimation is almost always seen as part of this disease.

Most of these cases do not survive to adult life. They should be kept out of the sun as much as possible. The treatment for the keratoses and carcinomas is the same as in the senile skin.

*Cutaneous Horn.*—This interesting and uncommon lesion may occur any place on the skin or exposed mucous membrane with a distinct predilection for the lips and the male genitalia. This lesion is always precancerous if not already cancerous when first seen. The lesion should be removed but always the base should be thoroughly cauterized with actual heat or treated with x-ray or radium.

*Nevi.*—Except for the blue black or slate grey mole, degeneration of nevi is an extremely rare thing. The blue black or slate grey mole is very important as a premalignant lesion. These lesions with and without irritation degenerate into the very malignant melanoma or melanosarcoma, which metastasizes very rapidly and which is almost always fatal in the best of hands.

They should be left entirely alone unless they are in areas prone to be irritated. If they are removed it should be by *wide surgical excision only*.

## Group II

*Group II.*—Block<sup>1</sup> considered the x-ray skin, leukoplakia and other lesions included to be a suitable terrain for the development of keratoses and ulcerations which are precancerous in nature. The appearance of degeneration is less common in this group than in Group I.



*X-ray and Radium Dermatitis.*—The effect of too much x-ray and radium on the skin exposed to the rays is analogous to the changes in the senile skin. The normal aging is hastened. In a few weeks to ten, fifteen, or twenty years, depending on the amount of exposure, atrophy, pigmentation and telangiectasia appear. The x-ray skin is an excellent terrain for the development of precancerous keratoses and ulceration. Degeneration does not occur as frequently as in the senile skin, xeroderma pigmentosa, etc.

X-ray or radium dermatitis except from purposeful radiation for internal and external malignancies is today inexcusable. The early workers with radium and x-ray by their experiments on themselves and their patients have demonstrated to us the dangers and precautions necessary in its use. The improvement in x-ray equipment and methods of measuring the R output have put the responsibility directly on the operator. X-ray and radium should only be used by physicians trained in their use and cognizant of their dangers. Our laws should be stiffened to make it unlawful for unscrupulous cosmeticians and other quacks to use it, particularly for epilation.

Prevention of x-ray dermatitis is the most effective method of cure. The unfortunate person who is afflicted by radiation dermatitis with or without precancerous ulcers or keratoses should be under the constant surveillance of a trained dermatologist. As the keratoses and ulcers appear they should be treated by actual cautery or by excision and skin graft. The use of aloe vera as introduced by Wright<sup>3</sup> can be advocated in selected cases.

*Leukoplakia.*—The whitish glistening lesions of various size which are seen on the mucous membrane of the mouth, genitalia and anus are known as leukoplakia. Microscopically the lesion is similar to the senile keratosis. The etiology of leukoplakia consists chiefly of chronic irritation. It is much more common in untreated and poorly treated syphilitics, particularly on the tongue and genitalia. Jagged teeth, ill fitting dental appliances and smoking are important as etiological causes in both syphilitics and non-syphilitics.

Leukoplakia is a good terrain for the development of chronic ulceration and proliferation, which occasionally leads to squa-

mous cell degeneration. Block<sup>1</sup> felt that leukoplakia only rarely led to cancer.

The treatment of leukoplakia should be to remove any irritating cause. Tobacco and hot spicy foods should be taboo. The dental hygiene should be improved and jagged teeth and roots removed. The leukoplakia should be under constant surveillance. Wide cautery of the area should be used as soon as any sign of fissuring, proliferation or irritation appears. Often vulvectomy is indicated in extensive cases of the female genitalia.

*Erythroplasia.*—Erythroplasia, commonly known as erythroplasia of Quérat, is one of the rare precanceroses. It is found on the mucous membranes of the mouth and genitalia in the form of well circumscribed erythematous lesions. Syphilis is not regularly present. It grows very slowly and persists indefinitely, being resistant to topical application. It should be destroyed by excision or local destruction, as it sooner or later develops into squamous cell carcinoma with early metastasis.

*Kraurosis.*—Kraurosis, though it has been described as occurring on the male glands and prepuce, is almost always found in women of advanced age or younger women in whom the condition had been prematurely brought on by hysterectomy and bilateral oöphorectomy.

There is usually a period preceding the atrophy during which the patient complains of an intractable pruritus vulvæ. With the atrophic stage the labia minora becomes almost nonexistent, the vaginal orifice is decreased in size. The nymphæ, clitoris and its hood and the vestibule are involved in the process. The mucous membrane becomes thin, glistening, tense and glossy as if it were varnished. Occasionally areas of leukoplakia are scattered throughout it. Carcinomatous degeneration will occur in many of these cases in time.

The etiology of kraurosis is indefinite. Many cases have some disturbance of the ovarian function. Gonorrhea, leukorrhea and other causes have been mentioned.

The treatment is chiefly vulvectomy in the severe cases and expectant treatment in the milder. Cautery of the leukoplakic areas is sometimes indicated. Endocrine therapy has helped in isolated cases. X-ray or radium therapy is contra-indicated.

## Group III

*Group III* lesions are mentioned briefly. Degeneration is extremely rare, in fact so rare that it is questionable whether some of these should be considered as precancerous.

*Seborrheic Keratoses.*—Only a few authenticated cases of carcinoma developing from seborrheic keratoses have been reported. These were probably a coincidence. The seborrheic keratosis is not a precancerous lesion in comparison to the senile keratosis.

*Lupus Erythematosus.*—The discoid lupus erythematosus lesion very rarely degenerates into cancer.

*Lupus Vulgaris.*—It is said that 1 to 4 per cent of untreated extensive cases of lupus vulgaris eventually lead to cancer. Lupus vulgaris is extremely rare in this country and lupus carcinoma even rarer.

*Scars.*—Extensive scars, especially those

resulting from burns, are a suitable terrain for the development of premalignant ulcers and keratosis. In practice the appearance of cancer in scar tissue is rather rare.

*Papilloma of the Mucous Membrane, Particularly the Tongue.*—Papillomas occasionally are seen on the tongue. Histologically they resemble verrucae. They rarely degenerate into cancer of the squamous cell type. They should be destroyed by cautery as a precautionary measure.

## Conclusion

The precancerous skin and mucous membrane lesions have been called again to the readers' attention. Their early adequate treatment has been stressed as a means of decreasing the frequency of carcinoma.

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## SOME UNCOMMON SKIN TUMORS\*

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Having selected a group of unusual skin tumors for presentation to this meeting I feel that I must defend my choice against two possible objections. The first point is that the tumor problem is not strictly a dermatological issue. We share this field in diagnosis and treatment with pathologists, surgeons and radiologists. The dermatologist, however, is frequently the first one called upon by the patient to decide whether a certain pimple or sore is or is not a new growth. In addition, surgeons and general pathologists have usually more important problems on their hands than the small things with which we shall concern ourselves now. As a matter of fact, most contributions to the study of epidermal tumors have been made by skin specialists, and have been published in dermatological journals.

The second cause for criticism is that the number of these publications is so large that one can feel that there has been said and written just enough. In view of the advances of experimental and other fields of cancer research the presentation of an additional four atypical cases may appear hardly worthwhile. Against this objection I feel that I can do no better than cite the words which my late teacher Dr. Jadassohn said when he presented a paper on rare epitheliomas to the German Surgical Society, in

1926. As long as the problem of cancer has not been solved, he argued, we still have reason to ascertain and to enlarge the one foundation on which any medical research rests, that is the morphological basis. We undertake such studies not only because we take delight in the description; we hope that by these means we shall make progress in the diagnosis, prognosis, therapy, and maybe even in our knowledge of the etiology of the epitheliomata.

Ewing also, in a recent paper, stresses the importance of histological tumor diagnosis, and particularly of histogenetic diagnosis.

It seems to me that for this purpose the analysis of individual atypical cases may prove more valuable than the statistical survey of a large material. That is the reason why, from more than one hundred skin tu-

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mors biopsied at Eloise Hospital in the year ending June 30, 1937, four uncommon cases were selected for this presentation. I shall try to use these cases for the discussion of some problems of classification and histogenesis of the epithelial tumors of the skin.

Table 1 gives a none too complete survey of those more or less benign epithelial tumors which are frequently referred to as

basal cell carcinomata which in their early stages imitated the benign type. The issue is of theoretical and practical importance, and our cases may help to decide the question.

*Case 1.*—A white man, fifty-seven years of age, never paid any attention to the numerous small moles on his face. Within the last two years, however, several of them have started growing, and

TABLE 1. "NEVOID" EPITHELIAL SKIN TUMORS

	Structure resembling			
	Epidermis	Hair Follicles	Sebaceous Glands	Sweat Glands
well differentiated	Verruca Senilis		Adenoma Sebaceum	Hidradenoma
	← MULTIPLE BENIGN CYSTIC EPITHELIOMATA →			
	← Epithelioma adenoides cysticum →			
intermediate		← Trichoepithelioma →		Syringoma
	← Case 1 →			
	← Case 2 →			
undifferentiated	← MULTIPLE BASAL CELL CARCINOMATA →			

"nevroid." The various types are arranged vertically according to their higher or lower degree of differentiation, and are grouped with those epithelial structures which they resemble most closely.

Glancing through the list there are just a few points that need discussion. I have put the senile verruca—as differentiated from senile keratosis—into one line with adenoma sebaceum and hidradenoma because this type of lesion appears to fulfill all the requirements of a benign "nevroid" well differentiated growth reproducing the normal structure of the epidermis with such modifications as may be expected in an "adenomatous" formation. For similar reasons Becker has proclaimed the senile wart as the "benign epidermal neoplasm" in the strict sense.

We find our first two cases listed between the benign cystic epitheliomas and the multiple rodent ulcers. There has been some controversy whether the true Brooke's epithelioma ever becomes malignant or not. Although less than twenty instances have been reported in the literature, in a recent article Summerill and Hutton hold that all these cases do not really belong to the epithelioma adenoides cysticum group, but rather that from the beginning they were

have become ulcerated. Distributed over the face, mainly in the central parts and around the eyes, there were about thirty tumors, most of them ranging from millet seed to split pea size. They looked like moderately pigmented or non-pigmented soft moles. There was, however, no overgrowth of hair associated with any of the lesions. At close inspection a large number of still smaller lesions and many milia could be seen. Some tumors were larger, and either had an adherent crust, or exhibited the rolled pearly edges of rodent ulcer.

Biopsies were taken from three of the rodent ulcers, and a dozen of the smaller lesions were excised as a therapeutic measure. The great majority of the biopsies exhibited the typical picture of epithelioma adenoides cysticum: well encapsulated basal cell growths in finely arborizing and budding arrangement including many horn and colloid cysts. There were some less common though not singular features associated: some of the tumors contained considerable amounts of melanin. The stroma was often hyalinized to an extreme degree, and the hyaline material frequently gave the reactions of amyloid. Calcified globules were found both in the epithelial strands, and free in the connective tissue. In two instances true bone formation was encountered.

The origin of these tumors from hair follicles appears likely because of the close association of small growths to lanugo hairs, and by finding abnormal hair follicles in all stages of transformation into "trichoepithelioma." As a matter of fact it often appeared that practically any hair in the sections might be the potential site of a new tumor. The sweat glands were unaffected except in one lesion in which epithelial strands of a somewhat different type apparently originated from the coils.

The biopsies from the clinically malignant growths had the typical structure of invading basal cell carcinoma: no capsule, and a more or less abundant reactive infiltration with lymphocytes and plasma

cells. Convincing signs were found that these tumors had originated by transformation from the benign growths.

Thus we have here a case of typical epithelioma adenoides cysticum with malignant degeneration of some of the lesions.

*Case 2.*—The next case is that of a white woman, seventy-three years old, who had a typical basal cell cancer on her nose and a small lesion on her left cheek resembling a sebaceous cyst, but suspicious of malignant change. In addition there were several soft pigmented moles with long hairs. On the forehead some small nevus-like lesions were noticed, and the patient stated that as long as she could remember the skin of the forehead "felt fixed to the bone." The lesion on the nose had developed from a small mole and had been growing for more than a year.

Biopsies were taken from the two epitheliomas, and two of the small tumors of the forehead were excised. Of these, one was a perfect match to the lesions in Case 1, even to the presence of amyloid in the stroma. The other lesion was quite similar, but was surrounded by a more highly cellular capsule of young connective tissue. The biopsy from the cheek had a structure approaching an ordinary basal cell carcinoma with strong reactive infiltration around the epithelial masses. The lesion from the nose showed infiltrating strands of basal cells with all the signs of local malignancy, but here again amyloid was found in the stroma.

We thus have a perfect series from the benign cystic epithelioma type to the ordinary basal cell cancer with some evidence of the latter having developed from the former. Clinically the benign lesions were so unobtrusive in this case that it would have passed as a case of multiple basal cell cancers, had not curiosity prompted us to take biopsies from the forehead, too.

Table II gives a classification of the malignant epidermal tumors of the skin, taking into consideration the contributions which various authors have made to this question within the last nineteen years. While intra-epidermal carcinoma was something almost unknown when Jadassohn first directed attention to such cases in 1918, there is now a definite group of diseases which must be classified under this heading. We, therefore, separate the intra-epidermal

carcinomas, growths showing all the cytological characteristics of malignancy without the histological features of invasion and destruction, from the trans-epidermal malignancies which have pierced the barrier of the basal membrane and infiltrate the underlying structures.

According to cell type we have been accustomed to differentiate basal cell and prickle or squamous cell epidermoid carcinoma. Darier and Ferrand, in 1922, stressed the importance of so-called "metatypical" forms of epidermoid carcinoma, the two most common groups of which are the mixed baso-squamous and the intermediary cell (not transitional cell) carcinomas. Soon German and American authors (Juon, Montgomery) concurred with this view. About 15 per cent of all carcinomas of the skin were found to be metatypical, a fact of great practical importance as most of these lesions resemble basal cell carcinoma clinically, while in their resistance to irradiation they approach the squamous cell type. More recently Martin and Stewart have collected a group of spindle cell epidermoid carcinomas of high malignancy, which histologically imitate spindle cell sarcomas.

Instances of intra-epidermal carcinoma of all of these types have been described. Jadassohn described the basal cell form; he and Montgomery saw mixed baso-squamous cell cases. Fraser has pointed out that Bowen's disease is not really a precancerous dermatosis, but exhibits all the cytological signs of malignancy. Since squamous cell carcinoma is the usual sequence of Bowen's disease we may take this disorder as the squamous cell type of intra-epidermal carcinoma. Intra-epidermal development of

TABLE II. THE MALIGNANT EPITHELIOMATA

Mode of Growth	TYPE OF MALIGNANT CELL				
	Basal Cell	Prickle Cell	Metatypical Forms		
			Spindle	Mixed Baso-Squamous	Intermediary
Intra-epidermal	Intra-epidermal Basal Cell Carcinoma (Jadassohn)	Bowen's Dermatitis (Fraser)	Case of Martin and Stewart	Cases of Jadassohn, Montgomery	Case 3
Trans-epidermal (invasive)	Basal Cell Epidermoid Carcinoma (Krompecher)	Squamous Cell Epidermoid Carcinoma Case 4	Spindle Cell Epidermoid Carcinoma (Martin & Stewart)	Metatypical Forms of Darier and Ferrand (Joun, Montgomery)	



spindle cell carcinoma was seen by Martin and Stewart. I was fortunate enough to get a specimen of the intermediary type that may serve to discuss the connections of Paget's disease to this group.

*Case 3.*—A white woman, seventy years old, had had a small warty growth on her right thigh for more than a year. The lesion had ulcerated lately. A biopsy was taken, and the diagnosis of intra-epidermal carcinoma was made. The entire tumor was then excised.

Paraffin sections show the epidermis considerably enlarged by the presence of smaller and larger nests of uniform cells with nuclei resembling those of the surrounding prickle cells but having a vacuolated protoplasm without fibrils. Mitoses are frequent in these cells which in many places form the largest part of the epithelium with only the basal layer and thin bands of normal squamous cells left. The basal layer is intact throughout. So are hair follicles and sweat ducts, of which several can be followed through the epidermis.

We have the development of an autonomous growth of epithelial cells within the normal boundaries of the epidermis. The cells forming the new growth are neither basal nor squamous, but are of the type called "intermediary cells" by Darier. While most of the growth forms compact nests in the epidermis, some of the malignant cells have become separated and are seen isolated or in small groups surrounded by normal rete cells. These cells resemble strikingly the characteristic clear cells of Paget's disease.

The view has become quite general that Paget cells are malignant cells. While some authors hold that they are of epidermal origin the work of Muir appears to have conclusively proven the theory first advanced by Jacobæus that at least in the cases involving the nipple the cells are due to intra-epithelial spread of a cancer of the lactiferous ducts. As to extra-mammary cases opinions vary. Some authors claim that there is no extra-mammary Paget's disease. Cases near the mucous membranes may be explained on a basis analogous to the nipple lesions. The case we have just considered opens the possibility of so-called extra-mammary Paget lesions being examples of intra-epidermal epidermoid carcinoma of intermediary cell type.

*Case 4.*—The last case is a frank example of squamous cell carcinoma, but had a highly unusual clinical aspect. A white man, fifty years old, was admitted to Eloise Hospital because of subacute bacterial endocarditis. His right upper lip appeared notched, and there was a yellowish-white slightly depressed scar-like plaque the size of a quarter which occupied the central third of the right upper lip. The surface was smooth and shiny and covered by an atrophic epidermis beneath which some large blood vessels were clearly seen. Hair follicles were lacking. The patient's wife related that the lesion had been present for at least twenty-five years, and that the retraction of the lip by the scarring process had made very slow progress.

The entire lesion resembled very much a circumscribed scleroderma except for the lack of the characteristic lilac ring. The diagnosis of morphea seemed to be substantiated at first when palpation revealed the sclerotic firmness of the diseased part. The infiltration, however, was so hard that even scleroma was taken into differential diagnosis. Recalling a somewhat similar case I had seen demonstrated in the East, I also considered morphea-like carcinoma.

The patient died shortly afterwards, and at autopsy tissue was excised for histological study. Unfortunately no picture had been taken during life. Thus the photograph is marred to some degree by the incision. The sections show narrow strands of epithelial cells infiltrating the entire cutis, apparently filling the lymph spaces, and extending downward along the sheaths of blood vessels and nerves. Every once in a while the strands swell up and include a small, well-formed horn pearl. Mitoses are extremely rare. No other malignancy was found in the body, and there was no metastasis to the local lymph nodes.

I have been unable to find a similar case in the literature although the term "morphea-like epithelioma" which seems to fit the case perfectly has been used variously in the literature. American and European authors seem to have used the term with different meaning. In France and Germany "scleroderma-like carcinoma" is applied to a rare and peculiar form of metastatic carcinoma growing slowly but extensively in the lymph spaces of the cutis, the primary tumor being usually in the breast. Crocker-Pernet have given the designation "morphea-like rodent ulcer" to a peculiar slightly raised yellow-white plaque which ulcerated after many years and was found to be basal cell carcinoma. A few similar cases have been reported in the American literature. If histological examination was done basal cell carcinoma was found in every instance.

This appears much more natural in view of the very slow development of the lesion. To find a squamous cell carcinoma was highly surprising. The case is an example of veritable scirrhus of the skin, a sclerosing squamous cell carcinoma.

Before I finish I wish to emphasize the value of biopsy for the diagnosis and treatment of skin tumors. In all the four cases reported histological study was of decisive importance in order to arrive at a correct diagnosis. Correct diagnosis is necessary for the selection of the adequate mode of treatment. This holds true not only in exceptional cases like those just discussed. The fact that in the material of three large clinics in France, Germany, and the United States 15 per cent of all skin cancers were found to be of metatypical structure im-

presses upon us the necessity of histological diagnosis in every case of carcinoma. Ewing, in a paper on the diagnosis of cancer, writes that "the removal of a small carefully selected portion of an accessible tumor seldom results in any harm." The neglect of biopsy, however, we may add, may cause delayed or insufficient treatment, and may definitely decrease the chances of a favorable outcome.

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## DYSTONIA OF THE VEGETATIVE NERVOUS SYSTEM

### Value of Specific Sedation in the Treatment

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The marked increase in the number of persons coming to us each year with symptoms of functional nervous disorders warrants more thoughtful consideration than has been given them in the past. The very fact that they have gone from one physician to another without benefit suggests that the mode of therapy has been inadequate. It has not sufficed to tell the patient there is no organic trouble present and to dismiss him with the statement that it is his "nerves." He suffers as much from his disturbed physiologic processes as does the individual with influenza and seeks relief just as eagerly. We must recognize that the local symptoms are reflections of an underlying general disturbance resulting from ineffective physiologic reactions of the individual to his environment. This acknowledgment permits us to view the patient as a whole and to institute a therapeutic regime that will be beneficial.

Functional disturbances of the autonomic system manifest themselves by a wide range of subjective symptoms, some of which are due to vagus excitation while others result from sympathetic over-activity. When imbalances first start, it is quite probable that a state of pure vagotonia or sympathicotonia exists; however, a primary disturbance of one type quickly induces imbalance of the corresponding antagonistic nervous regulation of the same organ. Subsequently, other imbalances arise with increasing complexity of symptoms, the character and intensity of which depend upon the portions of the autonomic system affected, and the degree to which normal functions are impaired. In addition, and because of the close functional as well as anatomical interrelationship of

the autonomic structures with the central nervous system, there is often found an associated psychic or neurotic element in the symptom-complex. In fact, Weiss and Collins,<sup>7</sup> as well as others, have noted that patients with autonomic dystonia are often regarded as suffering from a neurosis because of the more obvious abnormal psychic state. We feel that the psychic states of fear, anxiety, apprehension, worry, and mental strain are the precipitating factors in the etiology of the dystonia, acting on the hereditary predisposition to developing such an imbalance.

The psychic or conscious processes, located in the central nervous system, are largely concerned with the adjustment of the individual to his surroundings. The vital processes of the body are involuntary, and are regulated by the autonomic nervous system by means of reflex nervous reactions of varying degrees of complexity. The maintenance of normal functions, such as heart action, blood pressure, body temperature, and metabolism, depends upon a proper bal-



ance between sympathetic and parasympathetic activity. Sympathetic excitation increases the expenditure of energy, increases oxygen consumption, raises blood pressure, quickens the heart rate, and increases metabolism. Parasympathetic stimulation conserves energy, decreases oxidation, slows the heart rate, depresses metabolism, and lowers blood pressure.

Pottenger,<sup>5</sup> Crotti,<sup>1</sup> and others, have described the response of the various organs enervated by the autonomic system to an over-active vagus or sympathetic. Crotti lists the following reactions to vagotonia: contracted pupils, increased Dalrymple and von Graefe signs, increased lacrimation, increased naso-laryngeal secretion, and increased salivation, laryngospasm, increased bronchial secretion with bronchial spasm, slowing of the heart, vasodilatation, lowering of the blood pressure, hypersecretion, hypermotility of the gastro-intestinal tract, irritable bladder with spasm of the neck of the bladder, sweating and diminished body heat, lowered metabolism.

For sympathicotonia he gives: dilatation of the pupils, protrusion of the eyeballs, lessened lacrimal secretion, dry mucous membrane of the nose and throat, hypomotility and hyposecretion of the gastro-intestinal tract, relaxation of the intestinal musculature leading to a certain amount of gastro-intestinal dilatation, rapid pulse, constriction of peripheral blood vessels and slight rise in blood pressure, hyperglycemia, diminution of urinary output, increased sweating, increased body heat and increased metabolism.

The hyperthyroid state is a good example of the mixed symptomatology of autonomic dystonia. The increased body temperature, the rapid heart, the tremor, and exophthalmus result from sympathetic stimulation; whereas, the diarrhea is due to parasympathetic overactivity. Ordinarily, the predominant symptoms of hyperthyroidism are sympathetic in origin; nevertheless, Crotti has called attention to the fact that occasionally the outstanding symptoms may result from parasympathetic stimulation.

The spastic colon, sometimes called spastic colitis, has been cited as representing a pure vagotonic state. The symptoms of this condition, however, are undoubtedly greatly aggravated by emotional upsets on the part of the patient. Consequently, psychic disturbances must be considered as factors in

the symptom-complex of both the pure and mixed types of autonomic dystonia. Peptic ulcer, bronchial asthma, Raynaud's disease, diabetes mellitus and hyperthyroidism are probably either basically due to autonomic imbalance, or closely associated with this pathologic functional state.

In view of the vague and, at times, manifold symptomatology presented by patients with autonomic dysfunction, and because of the inadequacy of the usual therapeutic adjuncts, we felt that a different approach to this problem was desirable. Instead of medication for the control of the outstanding symptoms, as had all too frequently been employed, it seemed much more logical to administer a combination of drugs designed to produce sedation of the central nervous system, as well as both divisions of the autonomic nervous system. Bellergal, represented by the manufacturers to be a sedative of the entire neuro-vegetative system, appealed to us as the most logical type of medication required by these patients.

Each bellergal tablet is said to contain a combination of 0.0001 Gm. Bellafoline (levo-rotatory belladonna alkaloids) for vagus sedation; 0.0003 Gm. Gynergen (ergotamine tartrate) for sympathetic inhibition; and 0.02 Gm. phenobarbital, for central sedation. Seemingly, on first consideration, the joint administration of a vagus depressant and a depressant of the sympathetic division would merely result in a neutralization of the effects of both drugs, but pharmacologic studies have demonstrated that this is not the case, rather that each drug acts upon the respective nervous system for which it has a special affinity. Furthermore, the addition of phenobarbital to Bellafoline and Gynergen in no way impairs the joint effects of these two drugs. Both clinical and experimental studies have shown that Bellergal is an unusually effective sedative of the neuro-vegetative system.

Jores and Goyert<sup>3</sup> observed the action of this product upon vegetative functions and concluded that it effectively reduces vegetative irritability as determined by Aschner's ocular pressure test, the dermatographism reaction, pulse rate, blood pressure and temperature as measured both before and after the administration of epinephrine and pilocarpine. Forty patients with vegetative irritability were successfully treated with this combination. In this group were neuropathics of various types, nervous heart dis-

turbances, pseudo-ulcer cases and patients with peptic ulcer and spastic constipation.

Moore<sup>4</sup> states that functional nervous disorders may well be described as ineffective physiologic reactions of the organism to its environment. He calls attention to an increasing number of patients of this type coming to the attention of the physician and deplores the ineffective and casual treatment accorded them heretofore. Good results were obtained by the use of bellergal in his treatment of thirty-four patients with neuro-vegetative dystonia.

Forman<sup>3</sup> noted that the relief of menopausal symptoms, such as headache, nervousness and insomnia, afforded by the use of bellergal was striking and prompt. In obstinate cases, he supplemented its administration with œstrin. In psychogenic headache, Silverstein<sup>6</sup> found bellergal to be a splendid adjunct because of its excellent effect in causing a relaxation of the spastic state of the viscera and blood vessels, so commonly present in disturbed emotional states.

In our attempt to determine what effect this preparation has in the treatment of autonomic dystonia, we reviewed 217 consecutive cases in which bellergal had been administered in addition to our usual routine management. The majority of these patients were on a sanitarium regime consisting of physiotherapy, directed physical exercise, sunbaths, and prescribed diet. They were away from home and free from the worries and responsibilities entailed by their usual daily routine; consequently, any improvement, especially if only transitory, might be suspected to be due to the above factors rather than to the value of the bellergal. However, after discontinuing the sanitarium regime these patients have been followed for periods of six to eighteen months, during which time they have carried on their usual, and oftentimes increased, routine.

The inadequacy of evaluating the results of any therapeutic adjunct solely from the subjective response is readily admitted; nevertheless, in functional disorders due to autonomic imbalance, it is perhaps the best if not the only criterion from which conclusions can be drawn. The effects of adding bellergal to the individual regime is summarized in the accompanying table:

### Summary of Cases Receiving Bellergal

<i>Groups</i>	<i>Number</i>	<i>Percent</i>
I. Those exhibiting greatest improvement .....	52	24.6
II. Those exhibiting moderate improvement .....	138	63.5
III. Those exhibiting no improvement .....	25	11.0
IV. Those that were made worse.....	2	0.9
Total .....	217	100.0

In attempting to group the individuals, comparative values of personal response had to be used. Group I was made up of patients who were very enthusiastic about the efficacy of the tablets in completely relieving their symptoms. The migraine patients in this group were especially impressed with the action of Bellergal in preventing or ameliorating their symptoms in acute seizures, without regard to whether suffering from both headache and gastro-intestinal disturbance, or from only one of these symptoms. Some of the better reacting patients were those having a marked amount of intestinal flatulence and spastic constipation.

Group II was composed of those patients who were, likewise, definite as to the benefit received, but in whom the final result was still further improved by changes in dietary management, with the use of antacids and smooth, non-irritating bulk.

Group III were those patients who subjectively could determine no alteration in their symptoms whether taking the bellergal or not.

Group IV consisted of only two patients in whom the symptoms were definitely aggravated by taking the tablets. Both complained of dryness of the mouth, nausea, and a certain amount of mental foginess. We interpreted this as a probable sensitivity to the belladonna derivative. Discontinuance of the tablet relieved the condition, and the subsequent taking of it again brought on a return of the same symptoms.

The following are brief summaries of a few of the more interesting cases and their behavior under this form of treatment.

*Case 1.*—N. A., aged forty-two, white male, wholesale feed merchant, complained of periodic attacks of soreness in abdomen during past thirteen years coming on a few months after appendectomy for "chronic appendicitis." Associated had gas, bloating, alternate diarrhea and constipation and mucus in the stools occasionally. Examination revealed a patient slightly under weight; a spastic, tender descending colon, and a dilated, tender cecum. Roent-



gen examination of enteral tract revealed the head of the barium column in proximal transverse colon at end of the second hour and by the fourth hour it had reached the splenic flexure. At the eighth hour there was barium throughout. At the twenty-fourth hour, following three bowel movements there was still barium throughout; at the forty-eighth hour, following two more bowel movements, there was still a thin but definite trace throughout. The colon showed evidence of well defined hypertonicity. Cholecystogram was normal. Urine, stool, blood chemistry and qualitative blood examinations were negative. Proctoscopy revealed only small internal hemorrhoids.

Patient was given a bland diet, mucilose (Stearns) and a mixture of phenobarbital, belladonna and taka-diastase. Condition remained the same without improvement for one week when bellergal tablets, one before meals, were substituted for the above prescription. Within twenty-four hours patient felt much improved, the colonic soreness had disappeared and bowels were functioning normally. At the present writing (seven months later) patient has been free from recurrence and uses only one bellergal tablet and one dram of mucilose daily. Results excellent.

*Case 2.*—M. H., age forty-three, white male, vice president of a large manufacturing concern, was first seen in August 1934, at which time a diagnosis of duodenal ulcer, spastic colon and anxiety neurosis was made. A complete recovery was made on routine sanitarium regime. He returned in March, 1935, and January 1937, for periodic examinations and rest. In July, 1937, he returned again, complaining of nausea and vomiting of two weeks duration, that came on following a prolonged period of mental strain. With bed rest and the use of bellergal, one every three hours, patient was able to retain food after twelve hours, and to tolerate a normal diet on the second day. Bellergal was then prescribed one before each meal. He continued in good health and stopped the bellergal the middle of October 1937. The patient returned on November 5, in the midst of another attack of nausea and vomiting, and stated that he had been working extremely hard and traveling for the past seven weeks. He reported that he had no discomfort as long as he took the bellergal but that about two weeks after discontinuing it this present attack recurred. Treatment was again instituted; and he made a very prompt recovery. Results excellent.

*Case 3.*—L. H. P., aged thirty-six, white male, electrical repairman, was seen in June 1935, because of epigastric discomfort which had been present intermittently for twenty years. There was a history of the attacks lasting two or three days, and clearing up. Elsewhere for his trouble patient had his gall bladder and appendix removed, in the spring of 1931. He was well for one year, when the trouble recurred and became persistent with marked constipation, scybalous stools, gas and bloating. Examination revealed a markedly spastic colon and a dilated and tender cecum. The barium meal revealed a normal intestinal tract except for a markedly hypertonic colon. Proctoscopic, urine, stool, blood and food sensitization examinations were negative.

Mild sedation, antacids, and bland diet benefited him but little during the next several months. In December 1935, bellergal in usual dosage was prescribed, and he began to improve almost immediately. The discomfort cleared up, the bowels moved more satisfactorily, and he gained 12 pounds the first month. He has been seen periodically since, and has continued feeling fine except for an occasional short period of constipation. He has continued his daily routine during this entire period. Results excellent.

*Case 4.*—H. W., aged fifty-one, white female, has been under observation by my late chief, Dr. Elmer L. Eggleston, and myself, since 1920 for migraine, spastic colon and anxiety neurosis. April 10, 1936, patient was started on bellergal tablets, one before each meal. Two days later, complained of blurring of vision, marked dryness of mouth and some vertigo. The bellergal was stopped and the patient promptly recovered. This is one of the two patients who were apparently hypersensitive to the bellafoline content of the tablet. Results poor.

### Summary and Conclusions

Results of the use of bellergal as a sedative of the neuro-vegetative system, in addition to our routine treatment, in 217 cases of dystonia of the vegetative nervous system, have proved so satisfactory that we take pleasure in presenting them herein. One hundred and ninety patients (88.1 per cent) showed some form of improvement; fifty-two (24.6 per cent) showed what we classified as "greatest improvement"; 138 (63.5 per cent) were designated as "moderately improved." Two cases (0.9 per cent) showed what we interpreted as sensitization to the bellafoline, and the medication had to be discontinued.

Because of the period of time these patients have been followed in their daily routine we feel that the use of bellergal has a definite place in the ambulatory treatment of these cases.

None of the patients followed over this period has shown any deleterious effects from prolonged use of the drug.

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## President's Page

### IS IT THE OLD GAME OF "DIVIDE, AND RULE"?

THE first of the Cæsars did very well for himself and his party by putting action to the maxim: "Divide, and Rule." With varying degrees of success, the rule has been followed in every age and in every land since the Roman conquests. It is still being employed, in America and elsewhere, with just as much efficacy as in the year one, A.D.

The field of American medicine is not immune from attempts by some to utilize this very efficient proverb of the centuries. It seems apparent that a determined program has been developed to create civil war in organized medicine, for the purpose of weakening the unity of an efficient profession, and then to seize the reins and subjugate medical practitioners.

We read of attacks made by leaders of specialty groups; metropolitan papers play up the "Declaration of Independence" of a small minority committee; magazine articles by the score heap undeserved opprobrium on an altruistic profession. All to what purpose?

Is some force inside or outside the ranks of Medicine attempting to divide, and rule the profession? Are these vitriolic attacks the result of a carefully conceived campaign to develop a defeatist attitude among practitioners, and then quickly to foist upon the people a system of practice not in accord with American traditions and design of living? Are the medical figureheads in the van of attack being used as dupes by this force?

Doctor, you have made the answer. In fact, you and the many other thousands of members of organized medicine *are* the answer. There will be no repetition of "Divide, and Rule," so far as American medicine is concerned, if you remain constantly aware of current events, if you stand united against attacks within and without by active support of your County Medical Society, and if you not only know the truth but spread your knowledge to the people—day in and day out, every month of the year.

*Henry Cook*

President, Michigan State Medical Society.



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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JUNE, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### WHO FILCHES FROM US OUR GOOD NAME

THE Detroit daily papers, on May 5, published a front page story which gave the impression that the medical profession was guilty of grafting. At least, such would be the impression gained by the casual uninformed reader and listener, for, not confined to the printed page, the item was even broadcast by radio. The facts are: A year or so ago, a movement was sponsored by the Detroit Board of Health in the way of a campaign against tuberculosis. Suspected persons were to be given a tuberculin test by the family physician and positive reactors were to be referred to the roentgenologist for an x-ray examination of the chest to ascertain the presence of a minimal tuber-

culosis lesion or more extensive involvement. The tuberculin test was to be made by the family physician at a fee presumed to take care of the cost. The Detroit X-ray and Radium Society agreed that its individual members would make x-ray examinations at a fee that would take care of the actual overhead without any charge for the professional interpretation of the radiographs. To meet the expense, a sum of \$100,000 (this year, \$80,000) was appropriated by the council of the City of Detroit.

It was revealed that members of the profession received sums from a few dollars to over \$14,000 by one physician during the past year. The public were not told the circumstances. The physician receiving the highest sum practiced in a section of the city in which the colored portion of the population predominate. He, as might be expected, draws from a large clientele of colored doctors, and he evidently devoted a large portion of his time to this class of work. Considering the small fee paid for each x-ray examination, this seemingly large sum was largely overhead. Even at this, it is very much a matter of question (not in our mind, however) if the city did not gain by having these examinations made in the office of the private physician and roentgenologist rather than double the city equipment and personnel to do the work. This statement is made on the presumption that x-ray facilities at the Receiving and Herman Kiefer Hospitals are employed to capacity without taking on more work.

There is another phase to it. Two thousand doctors distributed over the city are in a better position to apprehend tuberculosis suspects and to round them up than were people voluntarily to visit any special examining center.

A little thought and investigation would have convinced anyone at all desirous of getting at the facts, that the appropriation made by the City of Detroit was as carefully spent from the viewpoint of efficiency of service as possible.

In spite of it all, the good name and altruism of the local medical profession was besmirched by both press and radio. With Othello, we say:

"Who steals my purse steals trash; 'tis something,  
 nothing,  
 'Twas mine, 'tis his, and has been slave to thousands;  
 But he that filches from me my good name  
 Robs me of that which not enriches him  
 And makes me poor indeed."

## GROUP MEDICINE

THE subject of group practice of medicine appears to be a perennial one for discussion. There seems to be no valid objection to physicians organizing as groups and, so far as the group idea per se is concerned, it does not involve the question of ethics at all. This JOURNAL has already declared itself on the subject as follows:

"One's opinion of group practice of medicine is likely to depend upon whether he is a member of the so-called 'group' or not. We do not wish to assume the role either of advocate or opponent. If our observations are of any value, they are to the effect that the group is an organization, an organic whole, with a dominant personality, around whom (if we may carry the metaphor farther) are recessive personalities. This in no sense implies the idea of superior and inferior. There are splendid minds who prefer to be relieved of details, especially of financing, and to work under leadership. This may be verified by reference to any of the well-known clinics. When we consider the long history of medicine, the group practice idea has not developed very widely nor extensively. . . .

"Individualism in medicine evidently has survival value or it would not have persisted throughout the centuries. Perhaps this lies in the important and peculiar relations that have always existed between doctor and patient; perhaps there is something after all in that professional secrecy which is guarded by common law under the technical term, *privileged communication*. The persistence of individualism may be due again to the independent type of mind that has chosen medicine as a profession. At all events we have it and we are not at all convinced that it is not an advantage to both patient and physician.

"The physician considering the matter of merging his identity into the group will do well to look to the possibilities of the future. While we know of medical groups the relations of whose members appear ideal, whose interests seem mutually satisfactory, we can sense a possibility in which a member might find it to his advantage to sever himself from the group, in which case he would have to begin practice all over."\*

A mere association of physicians in a single suite of offices or a medical building is not group practice. The objection to the group appears to be not so much to association as to the attempt on the part of the group to corral the practice of large sections of the population or of those employed in particular callings. In other words, when a group seeks something resembling a monopoly of practice (which is not often done), this of course interferes not only with other individual doctors, but with other groups as well; in this the chief objection lies. When an individual or a group of physicians succeeds through greater ability and attention to the details of med-

ical practice, there should be nothing but admiration. Where, however, either the individual or group tries to control certain sections of the population by other arrangement than by skill and competency, the practice is open to serious question.

## GROUP HOSPITAL INSURANCE

THE high cost of hospitalization has resulted in widespread efforts to meet it through the principle of insurance, whereby, for a nominal sum each month, employed persons may be able to take care of hospital expense in the event of prolonged disabling illness. The group hospital plan is meeting with a warm reception in a great many centers in the United States and Canada as well. Group hospitalization is something concerning which the medical profession has little say. It is an arrangement between the hospital or certain groups of hospitals and certain large groups of persons.

On the face of it, the doctor should view it with favor inasmuch as the possibility of having the hospital expense met through a fund established by the group makes it much easier for the patient to reimburse the doctor. It has happened so often, it almost is the rule rather than the exception, when the patient meets the hospital expenses, he has little or nothing left for the attending physician or surgeon. Therefore, what a boon it would be to the medical attendant if the hospital charges were out of the way. This is the favorable feature of the movement.

There seems to be a great deal of misconception and misunderstanding, however, as to what should be included under hospital care. The question is whether the services of the anesthetist, pathologist and roentgenologist should be included. The medical profession, for the most part, stoutly affirm that these services, constituting as they do the practice of medicine, should not be included in hospital care, but should be remunerated outside of routine hospitalization. The pathologist and roentgenologist are trained physicians, licensed to practice medicine. The anesthetist often is a lay person. Considering the fact that anesthesia consists in some form of administration of drugs, and that it demands of the anesthetist not only a clear knowledge of pharmacology and therapeutics, but of physiology and pathology as well,

\*Editorial, "Group Practice," page 250, vol. 32, 1933.



there is every reason that the administration of anesthetics should be a medical specialty. Where the anesthetist is not a qualified physician, he has to be sponsored usually by the surgeon performing the operation. However, the idea, the physician-anesthetist is more honored in the breach than in the observance.

The fact should be perfectly clear to every member of the profession, namely, to treat either the work of the pathologist, roentgenologist or anesthetist as a part of hospital care, constitutes the thin edge of the wedge whereby other forms of medical and surgical practice may be included, with the result that we would soon have institutional medical practice. There is too great a disposition on the part of all of us to disregard the thing that we think does not immediately concern us. We are impressed with the immediate rather than the distant view. It is only by a united and firm stand on the part of the medical profession that it is possible to maintain a definite understanding as to what constitutes hospital care and what constitutes medical and surgical care.

#### O, GI' ME A MAN

Oh, gi' me a man who is willing and true  
With a mind that is open and free,  
Wi' a heart and a hand in what he's to do  
For that's what a man should be.

Oh, gi' me a man wha can whistle and sing  
As he labors throughout the day,  
Who can think for himsel and judge of the thing  
That is best for his work and his play.

Oh, gi' me a man wha loves a guid hame  
For himsel and his bairnies and ma,  
Be it lowly and sma, or a castle o' fame  
It's the love that counts best of a'.

Oh, gi' me a man with a good deal of pride  
In his living, by nights and by days,  
For God has provided for man a guid guide  
To a service that's worthy o' praise.

WEELUM

To live content with small means; to seek elegance rather than luxury, and refinement rather than fashion; to be worthy, not respectable, and wealthy, not rich; to study hard, think quietly, talk quietly, act frankly; to listen to stars and birds, to babes and sages with open heart; to bear all cheerfully, do all bravely, await occasions, hurry never. In a word, to let the spiritual unhidden and unconscious grow up through the common. This is my symphony.

W. H. CHANNING (1810-1884)

## IN MEMORIAM

### Dr. R. S. Dupont

Dr. R. S. Dupont, of Detroit, died very suddenly in the latter part of April of cardiac disease. The doctor was born in Detroit seventy-two years ago, the son of Mr. and Mrs. William Dupont. He graduated from the University of Michigan in 1898. Dr. Dupont was a member of the Wayne County and Michigan State Medical Societies, and the American Medical Association. He is survived by his wife, Ruth B. Dupont, three sisters, Mrs. C. B. Vaughan, Mrs. W. Alfred Debo, and Miss Josephine Dupont, and a brother, Walter S. Dupont of Nevada.

### Dr. Edwin R. Espie

Dr. Edwin R. Espie died April 25, 1938, at Wiersdale, Florida, where he had lived the past six years. Dr. Espie was born at Moscow, Michigan, and was graduated from the University of Michigan Medical School in 1892. He was a former instructor in anatomy at the Detroit College of Medicine and a member of the Highland Park General Hospital staff. He had practiced many years at Highland Park and was a member of the Wayne County Medical Society. Dr. Espie was the father of Dr. Kenneth C. Espie of Kalamazoo.

### Dr. M. C. Hubbard

Dr. M. C. Hubbard of Vestaburg, died on May 1, at the Smith Memorial Hospital at Alma, Michigan. Dr. Hubbard had been in ill health for the past three years. He was graduated from the Detroit College of Medicine and had practiced at Vestaburg for thirty-two years where he was also very active in community and church affairs. During the World War, Dr. Hubbard was commissioned a lieutenant and stationed at Louisville, Kentucky. He was a member of the Gratiot-Isabella-Clare Medical Society and was on the staff of the Smith Memorial Hospital.

### Dr. M. N. Stewart

Dr. Maitland N. Stewart died on May 2 of a streptococcus infection through an abraded shin at Foote Hospital, Jackson. His death came as a shock to many of the citizens of Jackson who considered him a real friend. Dr. Stewart was born in Ruthven, Ontario, July 22, 1882. He was graduated from the Detroit College of Medicine and Surgery in 1905. After spending a year in Detroit as assistant city physician, he began private practice at Rives Junction in 1906, and in 1913 moved to Jackson. Dr. Stewart was very active in the Jackson County Medical Society, and in 1934 and 1935 was Chief of Staff at Mercy Hospital. Dr. Stewart is survived by his wife, three sons, Clayton, M. N., Jr., and Bruce Stewart; his brother, Dr. L. L. Stewart, and a sister in Detroit.



## BUDGETS

By Allison E. Skaggs and Henry C. Black

WHEN the word Budget is mentioned in connection with a well organized business, it means scientific planning of anticipated expenditures, but few doctors are familiar with budget operation in their own case, and many visualize it as an unpleasant procedure having something to do with compelling them to note down the 15c they spend for cigarettes, or the 50c for lunch. They are also handicapped by the uncertainty of their income.

The very fact that a man has the degree of "M.D." is proof that he has set himself a goal, planned his time, money, and energy for many years, and finally achieved it. *He planned it that way!* Then, upon entering practice he has more or less definite aims for attainment in the years to come. Possibly he wants to pay his debts, to attain financial independence, to have a large and appreciative number of patients, a fine reputation in his community, an opportunity for service to his profession, or to do research in some particular field. But does he plan and work toward his goal with the same care he used before?

The use of a flexible yet comprehensive budget will help much in attaining any goal involving finances and it presupposes adequate and accurate records. Let us make an example of Dr. X, who has been in practice five years, owes some money, wants to be free from debt, and make progress toward savings.

Basing his judgment on previous experiences, he lists the amounts he should spend each month for various business and personal expenses something like this:

Probable Monthly Income 1938.....	\$1,000.00
Probable Monthly Business Expenses 1938:	
Rent .....	\$ 60.00
Drugs & Supplies.....	75.00
Salaries .....	100.00
Stationery & Postage.....	15.00
Medical Conventions, Dues & Journals .....	15.00
Telephone & Telegraph.....	15.00
Car Expense .....	30.00
Interest .....	18.00
Miscellaneous .....	40.00
Depreciation Car & Equipment...	50.00

Total Business Expense.....	418.00
Profit .....	582.00
Personal & Living.....	\$400.00
Personal Life Insurance.....	50.00
Reduction of Debts.....	110.00

Total Personal Deductions.....	560.00
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Balance .....	\$ 22.00
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(NOTE: For best results income should equal the cash receipts and the various items of expense should be cash expenditures. Any accrual items usually become too involved for easy analysis.)

Now that a reasonable expectation of expenses has been listed, there becomes necessary a continual attempt to follow the budget closely, to keep it in mind when buying or spending. The answer to salesmen with ideas or merchandise that do not fit in the budget must usually be "No."

The best method for a doctor to use in attempting to follow a budget is to list his estimates as above on a columnar sheet and then fill in the actual figures each month in a succeeding column opposite the estimates. Then see how closely actual expenditures follow the estimates, note which items are running too high, and do everything possible to correct them.

If desired the "Personal and Living" expense item may be segregated in many different ways according to the needs and indications of the particular situation, but this usually requires the coöperation of the doctor's wife. There are readily available from numerous sources fairly accurate family budgets of proportionate expenses, but few professional men care to use them.

In so far as the budget for business expenses, life insurance and savings is concerned, too much emphasis cannot be laid on its importance. Many are the doctors who, after making no apparent headway for years, finally decide to do something about it and forthwith buy some monthly payment investment all out of proportion to their ability to pay. As a result they usually end up by forfeiting part of the value, or by working for years with their noses figuratively "on the grindstone" to pay for it.

Time spent now in establishing good financial records, monthly comparative reports, and a flexible yet well organized budget for business and personal expenses and investments, will save worry later.



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## PLACEMENT BUREAU

THE Placement Bureau of the Michigan State Medical Society is receiving numerous requests from physicians who desire to find suitable locations in this state.

Practitioners will aid themselves and other eligible doctors of medicine if they will notify the Executive Office, 2020 Olds Tower, Lansing, of any good locations or locum tenens opportunities which may exist. The Placement Service is trying to serve Michigan communities by supplying them with well-qualified doctors of medicine who are able to bring a high type of medical service to the people, rather than allow these districts to go unserved or to be forced to rely on the ministrations of lesser-qualified healers.

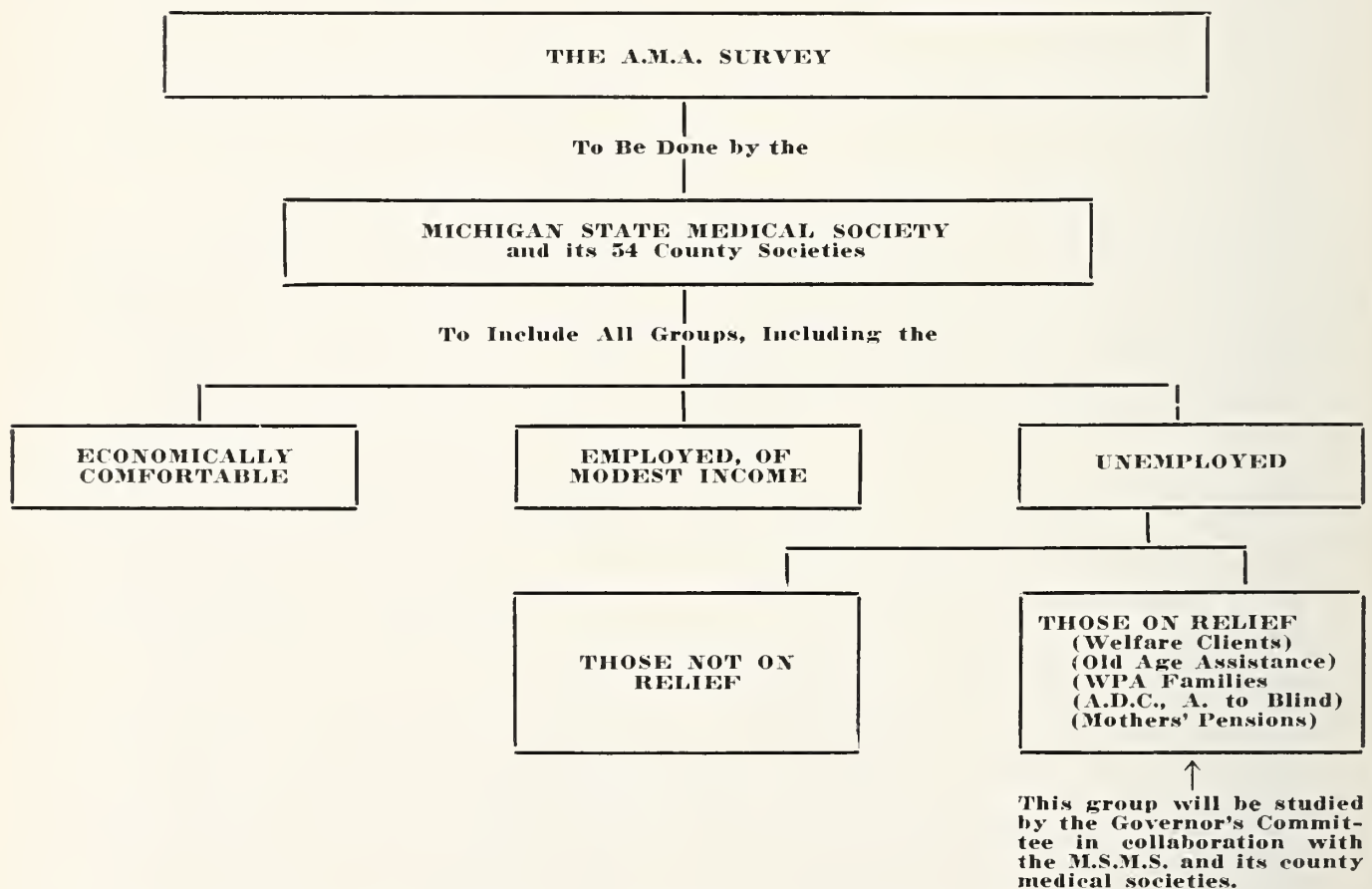
The Placement Bureau solicits your interest and help.

## A. M. A. SURVEY

OFFICERS of the county medical societies, component parts of the Michigan State Medical Society, are urged to invite individual members of the community to register with the county society the fact that he or she is not receiving necessary medical care.

Request the editor of your newspaper to run this request, as a boxed item, in several issues of the paper. This has been done, with splendid results, in several counties of the state. Such facts aid the A.M.A. Survey, and stimulate interest among other groups in your community who have something to do with the distribution of medical care.

The County Medical Society should investigate the various persons registering the fact that they are not receiving necessary



The study of all the other groups will be the sole responsibility of the State Society and its County Medical Societies

ALL STUDIES WILL BE CO-ORDINATED AS THE M.S.M.S. SURVEY

medical care. A determination should be made of what barrier exists between these people and the purveyors of health services. Such determinations will add much value to the A.M.A. Survey.

### FREEDOM EQUALS "VIGILANCE, NURTURE AND EFFORT"

"They were aloof to politics and disdainful and amused at the brown-shirted popinjay—with the fly under his nose—whose storm troopers stamped about shouting "Heil!"

Thus does Paul Marshall graphically picture two citizens of an erstwhile free country—an anthropologist and his wife—who enjoyed a charming home and a circle of friends representing the best of European culture.

These people, subjects of a book review by Mr. Marshall in the *Detroit News* of May 29, took *liberty* for granted. Then the ivory tower of freedom was smashed by politics, and these charming people became exiles. That the fault lay with themselves is summed up beautifully by Mr. Marshall in the following words:

"They take freedom for granted as a heritage and a right, rather than as an achievement requiring vigilance, nurture and effort. Somehow they do not comprehend that liberty is not divisible; that he who would guarantee it for himself must be alert to fight for it for others.

"They think smugly of culture as a thing apart. Yet unless it is founded on the whole people's life, how can it be a bulwark against tyrants?"

Mr. Marshall's sound words must be caught up and made an active part of *our* very lives—if we in America want a continuation of the freedom we enjoy today.

### OUTLINE OF GENERAL ASSEMBLY PROGRAM

Michigan State Medical Society Convention, Detroit, September 20, 21, 22, 1938

Hour	Tuesday September 20	Wednesday September 21	Thursday September 22
A.M. 9:30 to 10:00	FRANK H. LAHEY, M.D. Boston	SECTION MEETINGS	HENRY F. HELMHOLZ, M.D. Rochester, Minn.
10:00 to 10:30	HAROLD O. JONES, M.D. Chicago		RUSSELL L. HADEN, M.D. Cleveland
10:30 to 11:00	Intermission to VIEW EXHIBITS		Intermission to VIEW EXHIBITS
11:00 to 11:30	JOSEPH E. MOORE, M.D. Baltimore		KELLOGG SPEED, M.D. Chicago
11:30 to 12:00	HENRY A. CHRISTIAN, M.D. Boston		KATHARINE LENROOT Washington, D. C.
P.M. 12:00 to 12:30	A. D. RUEDEMANN, M.D. Cleveland		R. D. MUSSEY, M. D. Rochester, Minn.
12:30 to 1:30	Luncheon VIEW EXHIBITS	Luncheon VIEW EXHIBITS	Luncheon VIEW EXHIBITS
1:30 to 2:00	C. A. ALDRICH, M.D. Winnetka, Ill.	WM. D. McNALLY, M.D. Chicago	ROY R. GRINKER, M.D. Chicago
2:00 to 2:30	FREDK. J. TAUSSIG, M.D. St. Louis, Mo.	FRANKLIN G. EBAUGH, M.D. Denver	FRED. W. RANKIN, M.D. Lexington, Ky.
2:30 to 3:00	STANLEY J. SEEGER, M.D. Milwaukee	FRANK E. ADAIR, M.D. New York	HORTON CASPARIS, M.D. Nashville, Tenn.
3:00 to 3:30	Intermission to VIEW EXHIBITS	Intermission to VIEW EXHIBITS	Intermission to VIEW EXHIBITS
3:30 to 4:00	O. V. BATSON, M.D. Philadelphia	JOSEPH L. BAER, M.D. Chicago	A. F. VOSHELL, M.D. Baltimore
4:00 to 4:30	J. A. BARGEN, M.D. Rochester, Minn.	JOHN E. GORDON, M.D. Boston	HOWARD FOX, M.D. New York
4:30 to 6:00	VIEW EXHIBITS	VIEW EXHIBITS	END OF CONVENTION
8:00 to 8:30	Presentation of Postgraduate Awards	President's Night	
8:30 to 10:00	MORRIS FISHBEIN, M.D. Chicago	Biddle Lecturer: HAVEN EMERSON, M.D. New York	

All General Assemblies will be held in the Grand Ballroom of the Book-Cadillac Hotel



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## EXECUTIVE COMMITTEE OF THE COUNCIL

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April 14, 1938

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### HIGHLIGHTS:

1. A.M.A. Survey—Welfare clients and relief groups to be surveyed jointly by county medical societies in collaboration with the special medical survey committee appointed by the Governor.
2. President Henry Cook and Treasurer Wm. A. Hyland authorized to outline to a Committee of the U. S. House of Representatives, Washington, D. C., the place of the private medical practitioner in syphilis control work.
3. The American Medical Association is invited to hold its Annual Meeting in Detroit in 1939 or 1940 or 1941.
4. The Executive Committee reaffirms its belief that the Medical Filter, where operating without restrictions, represents the best method of successfully controlling intake of afflicted-crippled children.
5. The Michigan Supreme Court Constitutional Amendment, sponsored by the State Bar of Michigan, is endorsed.
6. The film "The Birth of a Baby" is approved for showing in Michigan.
7. Meeting of the secretaries of county medical societies in the Upper Peninsula, in Marquette, is authorized.
8. Request is made that county medical societies certify—thirty days in advance of the House of Delegates meeting in Detroit, September 19, 1938—the names of physicians whom they desire to nominate for special memberships in the State Society.

1. *Roll Call.*—The meeting was called to order by Dr. P. R. Urmston, Chairman, at 2:15 p.m. in the State Health Laboratories, Lansing.
2. *Minutes.*—The minutes of the meeting of March 13 were read, amended in one item, and approved as corrected.
3. *Financial Report.*—The financial report for March was presented. The amount of Cash on Hand from collection of annual dues resulted in motion by Drs. Moore-Brunk that ten Certificates of Deposit, each for \$1,000, be purchased at this time. Carried unanimously. Bills Payable were approved on motion of Drs. Greene-Moore. Carried unanimously.
4. *Woman's Auxiliary.*—Dr. H. S. Collisi, Chairman of the Advisory Committee to Woman's Auxiliary, reported on his meeting with the president and other officers of the Woman's Auxiliary in Grand Rapids on April 13. He discussed (a) the routine of procedure; (b) The interest of the Woman's Auxiliary in the film "Birth of a Baby"; (c) The program of the Woman's Auxiliary annual meeting, which is to include lectures and an exhibit on venereal disease. Motion of Drs. Greene-Brunk that tentative approval of the Woman's Auxiliary program for their annual meeting be given. Carried unanimously; (d) The Benevolent Fund was discussed; (e) The budget of the Woman's Auxiliary, to include any exhibit on venereal disease at the A.M.A. meeting, is to be presented at a later date to the Executive Committee.
5. *Film "Birth of a Baby."*—This was discussed, and motion was made by Drs. Greene-Brunk that the Executive Committee of The Council approves the showing of this film in the state of Michigan. The motion was carried, with Dr. Moore dissenting.
6. *Afflicted Child Law.*—Report was given by the

Executive Secretary on the Crippled Children Commission meeting of April 12-13, and the Auditor General's suggestion that all expenditures be scaled down.

Mr. Howett's recommendation re the medical filter committee was presented. Discussion resulted in motion of Drs. Moore-Brunk that the Michigan State Medical Society's Executive Committee of The Council reaffirms its belief that the medical filter as set up by the M.S.M.S., and where operating without restrictions, is the best method; that Mr. Howett's plan is fraught with danger and legal complications, and is economically unsound and impracticable. Motion carried unanimously.

7. *State Bar of Michigan.*—Messrs. Brand, Newton and Wolfenden of the State Bar of Michigan presented information on the forthcoming constitutional amendment, to be presented to the electors on November 8, 1938, re selection of Supreme Court Justices. Motion of Drs. Riley-Greene that the Executive Committee of The Council endorse the plan of the State Bar of Michigan. Carried unanimously.
8. *A.M.A. Survey.*—Activity on the A.M.A. Survey, to date, was presented by Secretary Foster. Dr. Urmston presented details of the survey of welfare clients which is proposed to be made jointly in collaboration with a special committee appointed by Governor Murphy.  
Dr. Gudakunst suggested a meeting of his special committee, with Drs. R. G. Leland, Cook, Urmston and Foster, in Lansing on May 4, 1938.  
A newspaper release on the meeting of May 4 was approved by the Executive Committee. The chart of agencies, developed by the Wayne County Medical Society, was studied and commended.
9. *Attorney General's Opinion re: X-Ray Interpretation.*—This was reported by Dr. Moore. A sat-

isfactory agreement is anticipated for the near future.

10. *Committee Reports.*—(a) Contact Committee with Parole Commission, presented by Chairman Riley. All matters are settled, and have been approved by the Parole Commission.

(b) Ethics Committee. The Chair reported on recent piece of good work by the Ethics Committee and its Chairman, Dr. Porter. Thanks and commendation were extended to the Committee.

(c) The monthly report of the Medico-Legal Committee was presented.

(d) The activities of the Committee on Scientific Work were reported by Dr. Foster.

(e) The Public Relations Committee report was presented by Dr. Foster.

(f) The Mental Hygiene Committee gave a report through its Chairman, Dr. Luce. He recommended that a Speakers' Bureau memorandum be sent out next year by the Michigan State Medical Society on "Mental Hygiene."

(g) Report of the work of the Legislative Committee was presented by the Chairman, Dr. Christian.

(h) Liaison Committee with Hospitals—report given by Chairman Gruber. Motion of Drs. Moore-Greene that the Executive Committee of The Council and the Liaison Committee of the M.S.M.S. meet with the Trustees of the Michigan Hospital Association. Carried unanimously.

11. *Delegates to A.M.A.*—The five delegates from the M.S.M.S. to the A.M.A. discussed various items, for possible presentation to the A.M.A. in San Francisco next June. Dr. Brook was elected Chairman of the Delegates.

(a) The Executive Committee of The Council approved the recommendation of the Delegates, that the M.S.M.S. send a telegram to the Secretary of the A.M.A. to hold its meeting in Detroit in 1939 or 1940 or 1941; this motion of Drs. Brunk-Moore was unanimously approved.

(b) The advantages of a Bureau of Public Relations of the A.M.A. were discussed thoroughly.

(c) Affiliate Fellowship in A.M.A. for Dr. Wm. P. Scott, of Houghton, was approved on motion of Drs. Moore-Riley, and recommended to the Delegates to present to the A.M.A. House of Delegates in June.

(d) The Chair called upon each Delegate for suggestions as to matters he may wish to bring up in San Francisco.

12. *Syphilis Control.*—President Cook reported on his and Dr. Hyland's recent trip to Washington, D. C., giving full details on his presentation to the Committee of the House of Representatives. The President was applauded for his good work in Washington.

13. *A.M.A. Meeting.*—Discussion as to what officers should attend the A.M.A. session resulted in the motion of Drs. Brunk-Moore that in addition to the Delegates from the M.S.M.S. to the A.M.A., the Chairman of the Council be authorized to go to the A.M.A. meeting in San Francisco. Carried unanimously.

14. *Legal Counsel for the M.S.M.S.*—This was presented, and discussed by Drs. Urmston and Greene. The matter is to be placed on the Agenda for the September meeting of the Council.

15. *Duties of Vice-Speaker of the House of Delegates, M.S.M.S.*—This was discussed and motion was made by Drs. Riley-Brunk that Chapter Four, Section Five, of the M.S.M.S. By-Laws is interpreted by the Executive Committee of the

Council to mean that the Vice-Speaker of the House of Delegates shall assume the duties of the Speaker at meetings of the Council and of the Executive Committee when the Speaker is absent. Motion carried unanimously.

16. *Commercial Group Hospitalization Plan.*—The Executive Secretary was authorized to contact the Insurance Commissioner re a so-called "non-profit" corporation, on motion of Drs. Brunk-Moore. Carried unanimously.

17. *A Brief on the Status of Chiropractors*, as developed by Mr. Burns, was approved. A copy is to be sent to each member of the Executive Committee of the Council.

18. *Meeting of Secretaries of the Upper Peninsula.*—This suggestion, made by Dr. C. D. Hart, Newberry, was approved on motion of Drs. Riley-Greene. Carried unanimously. The expenses of the conference were authorized.

19. *Honorary and Emeritus Membership.*—The suggestion that all county societies should certify names of members for special memberships to the Executive Committee thirty days in advance of the annual meeting of the House of Delegates of the M.S.M.S., to permit checking of membership history, was approved by the Executive Committee.

20. *Thanks to our Hosts.*—The Executive Committee placed a vote of thanks on its minutes to State Health Commissioner Don W. Gudakunst and to Dr. C. C. Young of the State Laboratory for their hospitality to the Executive Committee on this day.

21. *Adjournment.*—The meeting was adjourned at 10:00 p.m.

## COUNCIL AND COMMITTEE MEETINGS

1. Wednesday, May 4, 1938—Contact Committee to Governmental Agencies—Olds Hotel, Lansing—with the Governor's Survey Committee—6:30 p. m.
2. Wednesday, May 18, 1938—Maternal Health Committee—University Hospital, Ann Arbor—12:00, noon.
3. Friday, May 20, 1938—Advisory Committee on Tuberculosis Control—Olds Tower, Lansing—2:30 p. m.
4. Saturday, May 21, 1938—Contact Committee to Governmental Agencies—Olds Hotel, Lansing—with the Governor's Survey Committee—6:30 p. m.
5. Sunday, May 22, 1938—Preventive Medicine Committee—Statler Hotel, Detroit—3:00 p. m.
6. Sunday, May 22, 1938—Advisory Committee on Syphilis Control—Statler Hotel, Detroit—3:00 p. m.
7. Tuesday, May 24, 1938—MSMS Legislative Committee with WCMS Policy Committee—WCMS Building, Detroit—6:30 p. m.
8. Saturday, May 28, 1938—Cancer Committee—Woman's League Building, Ann Arbor—6:00 p. m.
9. Wednesday, June 1, 1938—Contact Committee to Governmental Agencies—Auditor General's Office, Lansing.
10. Thursday, June 2, 1938—Representatives of MSMS to Joint Committee on Health Education—Michigan Union, Ann Arbor—Noon.
11. Tuesday, June 7, 1938—Maternal Health Committee—Olds Hotel, Lansing—12:00 noon.
12. Sunday, June 12, 1938—Committee on Distribution of Medical Care—Olds Hotel, Lansing—2:00 p. m.



## SUPPLEMENTARY ROSTER

The following physicians, whose names did not appear in The Directory Number of THE JOURNAL, are members of the Michigan State Medical Society:

## Berrien County

Anderson, Bertha .....St. Joseph	Henderson, Fred .....Niles	Littlejohn, William .....Bridgman
Hart, Russell .....Niles	Henderson, Robert .....Niles	

## Calhoun County

Abbott, Nelson .....Marshall	Robins, Hugh .....Marshall	Sayre, Philip P.....South Haven
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## Eaton County

Gray, Arthur S.....Bellevue
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## Chippewa-Mackinac County

Cook, Carl S.....Mackinac Island	Rhind, E. S.....Rudyard
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## Genesee County

Boughton, Thelma .....Clio	Jickling, D. S.....Flint	Probert, C. C.....Flint
Burkett, L. V.....Flint	Kurtz, John .....Flint	Spencer, James A.....Flint
Corbett, Bernard .....Flint	Moore, John W.....Flint	Treat, D. L.....Flint
DelZingro, N. ....Davison	O'Neill, C. H.....Flint	Ware, F. A.....Flint
Grover, H. F.....Flint	Olson, James A.....Flint	Woughter, Harold .....Flint

## Grand Traverse-Leelanau-Benzie County

Willard, W. G.....Benzonia
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## Huron-Sanilac County

Ritsema, John .....Sebewaing
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## Lenawee County

Lennox, Arthur L.....Adrian
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## Marquette-Alger County

Bottum, C. N.....Marquette	Corneliuson, Goldie .....Lansing
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## Mason County

Farrier, Robert .....Ludington
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## Monroe County

Acker, W. F.....Monroe	Karch, A. W.....Monroe	Williamson, C. W.....Dundee
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## Oakland County

Bradley, Everett.....Pontiac	Hassberger, J. B.....Birmingham	Ohlemacher, A. P.....Royal Oak
Faust, Earl.....Hazel Park	Larson, B. T.....Pontiac	
Gatley, C. R.....Pontiac	Norup, John .....Berkeley	

## St. Joseph County

Pennington, H. C.....White Pigeon	Pierce, H. M.....Colon
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## Washtenaw County

Bethell, Frank H.....Ann Arbor	Folsome, Clair .....Ann Arbor	Williamson, F. B.....Ypsilanti
Britton, H. B.....Ypsilanti	Gates, Neil A.....Ann Arbor	Woods, J. J.....Ypsilanti
Bywaters, T. W.....Ann Arbor	Sawyer, Walter W.....Ann Arbor	

## Wayne County

Allison, Herbert C.....Detroit	Gannan, Arthur M.....Detroit	Lippold, Paul .....Detroit
Breitenbecher, E. R.....Detroit	Grandfield, F. J.....New Boston	Lipschutz, Louis S.....Detroit
Bracken, A. H.....Dearborn	Grimaldi, G. J.....Detroit	LaMarche, N. O.....Detroit
Campbell, Duncan A.....Detroit	Greenberg, Morris J.....Detroit	Mair, Harold U.....Detroit
Caton, Dorothy F.....Detroit	Hamil, Brenton M.....Detroit	Marks, Morris H.....Detroit
Chall, Henry G.....Detroit	Hinko, Edward N.....Detroit	McClellan, G. L.....Detroit
Clippert, Julius C.....Grosse Ile	Howell, Robert.....Eloise	Morse, Plinn F.....Detroit
Cooper, James B.....Detroit	Hulse, Warren L.....Detroit	O'Brien, E. J.....Detroit
Crane, L. T.....Detroit	Heath, Leonard P.....Detroit	Porter, H. J.....Romulus
Cushing, R. G.....Detroit	Hasner, Robert B.....Royal Oak	Peterman, E. A.....Detroit
DeHoratiis, Joseph .....Detroit	Isaacs, J. G.....Detroit	Reisman, N. J.....Detroit
DeTomas, Romeo Q.....Detroit	Israel, J. G.....Detroit	St. Louis, R. J.....River Rouge
Dillard, Malcolm P.....Detroit	Jonikaitis, Joseph J.....Detroit	Scarney, Herman D.....Detroit
Drinkaus, Harold I.....Detroit	Kay, Harry H.....Detroit	Sellers, Graham .....Detroit
Durham, Robert H.....Detroit	Keating, Thomas F.....Detroit	Seymour, W. J.....Detroit
Frank, M. N.....Detroit	Kubaneck, Joseph L.....Eloise	Sheridan, Charles R.....Detroit
Freund, H. A.....Detroit	Leach, David .....Detroit	Sherwood, D. L.....Detroit
Flaherty, H. J.....Detroit	Leithauser, Daniel J.....Detroit	Smith, Gerritt C.....Detroit
Galerneau, D. B.....Detroit	Lilly, Charles J.....Detroit	Vardon, Edward M.....Detroit

## Wexford-Kalkaska-Missaukee County

Wood, G. H.....Luther
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## WHAT COUNTY MEDICAL SOCIETIES ARE DOING

### MEDICAL EXAMINATION OF SCHOOL TEACHERS IN GRAND RAPIDS

BY WILLIAM R. TORGERSON, M.D.,  
*Grand Rapids*

THE medical examination of school teachers during the past year for the city of Grand Rapids in Kent County appears to have been accomplished with satisfaction to all concerned. It has been done through co-operation between the Kent County Medical Society and the Board of Education of Grand Rapids. In consideration of a specified payment from the Board of Education, the Kent County Medical Society agreed to examine all employees of the Board of Education for the year 1937-38, with the intention of continuing the arrangement by examining one-third of the old employes and all new employes each year. An examining commission of thirty members of the Kent County Medical Society are to continue work for fifteen weeks. This is at rate of fifteen employes daily for five days a week at a two hour period each day, namely from 3:30 to 5:30 p.m. The examination covers physical defects only and includes a blood examination for Kahn, a urinalysis and a tuberculin test. If, in the opinion of the examining doctor, x-ray, electrocardiogram or further blood examinations are indicated, it is the responsibility of the Board of Education to so recommend to the employe, who should have free choice of physician to carry out further examination. The routine does not include psychiatric examination, which, when necessary, is also to be arranged by the Board of Education.

The Board of Education provided the necessary rooms at headquarters as well as all necessary examination blanks and printed material. It is further the work of the Board to look after all clerical work in connection with these physical examinations. A reviewing board has been created, made up of three members of the Kent County Medical Society, whose function it is to check the examination reports and to re-examine such employes as may be found necessary.

Instructions to the examining committee are as follows:

1. Please note the day you are to examine and the dates carefully. The schedule is arranged so that half the committee serves the first eight weeks and the other half the last eight weeks. You will always examine on the same day.
2. The examining hours are from 4:00 to 6:00 p.m.
3. The examining rooms are on the fifth floor of the Board of Education Building, the same floor on which the Board of Education has its offices. (Take elevator to the fifth floor.) The Board of Education Building is adjacent to Davis Technical High School, 143 Bostwick, N. E.
4. Each doctor will examine five employes each day.
5. Bring your stethoscope and sphygmomanometer. Other equipment is furnished.
6. Each doctor is responsible for his day. If for any reason you cannot be there it is your responsibility to arrange with some other member of the committee examining at the time, i.e., the same eight weeks (see schedule), to take your place and you take his. Many such exchanges will disturb greatly the smooth running of the examinations so please do not change your day unless *absolutely necessary*.
7. You will place your blanks, after completing the examination, in file assigned to you. On your next examination day the laboratory reports will be found with your previous examination blanks. It will be your first duty to complete the previous week's examination blanks and make your recommendations to the Board.
8. If there are no physical defects you will note: "Physical Condition Satisfactory."  
"No recommendations."
9. If there are minor physical defects that would not disqualify employe note:  
"Physical Condition Satisfactory."  
Recommend:  
Dental Care.  
Check up nose and throat, etc.
10. If physical defects sufficient so that in your opinion employe should be disqualified note:  
"Refer to Examination Board."  
Question:  
Heart lesion  
Prostate  
Stomach trouble  
Eye defect  
Hearing defect, etc.
11. When you have completed the record put it in completed file or Examination Board file. Be sure and get it in the *proper file*.
12. The employe is to be given no advice. You can tell him that the examination is not completed until the laboratory reports are returned and if any physical defects are found the Board of Education will give him your findings. *He should then see his own doctor.*
13. Try and be prompt at the examinations. They will begin at 4:00 p.m.
14. If a pelvic examination is indicated explain to the employe that a specialist will make that examination. If the employe objects the issue *cannot be forced*. Also suggest to all women employes that a pelvic examination will be made by a specialist if they desire it whether indicated or not.
15. Team work and coöperation are necessary to make this project a success. It is up to every one on the committee to give freely and conscientiously of his time. If this year is a success the rest of the society members will be called upon in turn. *Please do your very best.*



## COUNTY SOCIETIES

### BAY COUNTY

A. D. LaFerte, M.D., of Detroit, spoke on "Orthopedics" and Dr. John Law, Ann Arbor, discussed "Acute Conditions of the Abdomen in Children" at the refresher meeting of May 11 in the Nurses Home, Mercy Hospital.

A. L. ZILIAK, M.D., *Secretary*.

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### BERRIEN-CASS COUNTY

Paul Willits, M.D., of Grand Rapids, spoke at the meeting of May 18 at Hotel Whitcomb, St. Joseph. His subject was "Pre-Natal Care."

Henry Ransom, M.D., of Ann Arbor, spoke on "The Acute Abdomen" at the meeting of April 20 at the Four Flags Hotel, Niles. Attendance, fifty-eight.

A. F. BLIESMER, M.D., *Secretary*.

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### CALHOUN COUNTY

Leslie Mitchell, M.D., Detroit, was guest speaker at the meeting of May 3 in the American Legion Clubhouse. His subject was "Low Back Pains."

Tom E. Jones, M.D., of Cleveland, spoke on "Diagnosis and Treatment of the More Common Diseases of the Colon and Rectum" at the meeting of April 5 held in the Athelstan Club.

WILFRID HAUGHEY, M.D., *Secretary*.

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### CHIPPEWA-MACKINAC COUNTY

Loren W. Shaffer, M.D., of Detroit, spoke on "Syphilis" at the meeting of April 1. The State Health Commissioner, Don W. Gudakunst, M.D., outlined plans for syphilis control work in Michigan.

D. F. SCOTT, M.D., *Secretary*.

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### EATON COUNTY

A symposium on Materia Medica and Therapeutics was presented at the May 19 meeting at the Carnes Tavern, Charlotte. C. S. Sackett, M.D., Charlotte, discussed "Belladonna"; A. Burleson, M.D., Olivet, spoke on "Quinine"; and C. Huber, M.D., spoke on "Calomel." These addresses were followed by a round-table discussion.

THOMAS WILENSKY, M.D., *Secretary*.

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### GENESEE COUNTY

Udo J. Wile, M.D., of Ann Arbor, was guest speaker at the meeting of April 6. His subject was "Problems of Dermatology and Syphilology."

C. W. COLWELL, M.D., *Secretary*.

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### HILLSDALE COUNTY

Harold Furlong, M.D., of Pontiac, spoke on "Contraceptive Techniques" at the March 24 meeting in the offices of the County Health Department, following dinner at the Keefer Hotel. J. E. McIntyre, M.D., Lansing, Councilor of the Second District, outlined the coöperative work of the State Board of Registration in Medicine and the Michigan State Health Department with regard to provisions of the Medical Practice Act.

E. G. MCGAVRAN, M.D., *Secretary*.

### HURON-SANILAC COUNTY

M. E. Vroman, M.D., of Port Huron, spoke on "Eye Refractions" and T. F. Heavenrich, M.D., of Port Huron, on "Coughs" at the meeting of March 17 held in Bad Axe, Michigan.

E. W. BLANCHARD, M.D., *Secretary*.

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### INGHAM COUNTY

A. J. Aselmeyer, M.D., Surgeon U. S. Public Health Service, Washington, D. C., spoke on "Report on the Ingham County Survey"; Harthur Keim, M.D., Detroit, spoke on "The Report from the Viewpoint of the General Practitioner," and Robert S. Breakey, M.D., of the Ingham County Medical Society Public Health Committee, presented recommendations for future control of venereal disease, at "State Society Night," May 17, Olds Hotel, Lansing. Introductory remarks were made by Henry Cook, M.D., Flint, President, and Loren W. Shaffer, M.D., Detroit, Chairman of the State Society Syphilis Control Committee, and by State Health Commissioner Don W. Gudakunst. Attendance—175.

The fourth annual clinic of the Ingham County Medical Society held at the Olds Hotel, Lansing, on April 28, attracted 190 physicians, many of whom were guests from neighboring counties.

R. J. HIMMELBERGER, M.D., *Secretary*.

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### IONIA-MONTCALM SOCIETY

A symposium on Preventive Medicine featured the Belding meeting of May 5. Those participating were L. O. Geib, M.D., Loren W. Shaffer, M.D., Henry F. Vaughan, Dr. P.H., Bruce H. Douglas, M.D., G. M. Byington, M.D., all of Detroit and State Health Commissioner Don W. Gudakunst.

JOHN J. MCCANN, M.D., *Secretary*.

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### JACKSON COUNTY

Fremont C. Vale, M.D., of Detroit, spoke on "Cancer of the Stomach" at the meeting of April 19 in Hotel Hayes.

H. W. PORTER, M.D., *Secretary*.

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### KALAMAZOO ACADEMY OF MEDICINE

John S. Coulter, M.D., Chicago, spoke on "Physical Therapy in Traumatic Surgery" at the meeting of May 17 in the Academy clubrooms.

Russell L. Haden, M.D., Cleveland, spoke on "Clinical Nutritional Deficiency Disease" on April 19 at the Nurses' Home of Borgess Hospital.

L. W. GERSTNER, M.D., *Secretary*.

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### KENT COUNTY

Fred W. Rankin, M.D., of Louisville, was guest speaker at the May 11 meeting in the Rowe Hotel.

Wm. R. Torgerson, M.D., Grand Rapids, spoke on "Our Leading Medical Men of the 19th Century" and W. M. German, M.D., presented six reels of Mexican films, at the meeting of April 29 in the Kent County Medical Society clubrooms.

J. M. WHALEN, M.D., *Secretary*.

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### LENAWEE COUNTY

A. P. R. James, M.D., of Toledo, spoke on "Differential Diagnoses and Treatment of Skin Diseases" at the March 15 meeting at the Lenawee Hotel in Adrian.

ESLI T. MORDEN, M.D., *Secretary*.

JOUR. M.S.M.S.

## LIVINGSTON COUNTY

The Livingston County Bar Association and the Dental Society were guests of the Livingston County Medical Society at its meeting of March 4 at the Sanatorium. This was the first meeting of its kind in the county, which will be continued as an annual event. LeMoyne Snyder, M.D., of Lansing, outlined his experiences as medico-legal advisor to the State Police.

D. C. STEPHENS, M.D., *Secretary*.

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## MIDLAND COUNTY

F. Bruce Fralick, M.D., of Ann Arbor, spoke on "Eye Diseases" and Harry Towsley, M.D., Ann Arbor, presented a motion picture on "Contagious Diseases in Children" at the meeting at Midland Country Club on May 12.

N. C. GREWE, M.D., *Secretary*.

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## MUSKEGON COUNTY

Michael L. Mason, M.D., of Chicago, was guest speaker at the meeting of May 22. His subject was "The Management of Open Wounds."

Hugo A. Freund, M.D., of Detroit, spoke on "Diseases of the Peripheral Blood Vessels" at the April 22 meeting in the Occidental Hotel.

L. E. HOLLY, M.D., *Secretary*.

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## OAKLAND COUNTY

The May meeting was held at the University Hospital, Ann Arbor, on May 11. A program on all phases of preventive and curative medicine was presented in the afternoon and evening by department heads of the University Hospital: Drs. F. A. Collier, Norman F. Miller, Carl Badgley, John Alexander, G. H. Belote, Raphael Isaacs, L. H. Newbergh and Frank N. Wilson.

Following dinner at the Michigan Union, Professor Carl Guthe gave a very interesting address on "Anthropology and Medicine."

O. O. BECK, M.D., *Secretary*.

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## ST. CLAIR COUNTY

Philip Jay, D.D.S., of Ann Arbor, spoke on "The Cause of Dental Caries" at the joint meeting with the St. Clair Dental Society at Black River Country Club, Port Huron, on May 17.

P. R. Urmston, M.D., and L. Fernald Foster, M.D., of Bay City, Council Chairman and Secretary respectively of the State Society, and Executive Secretary Wm. J. Burns of Lansing were present at the meeting of April 5 to discuss the "A.M.A. Survey" and activities and problems of medicine. Henry C. Gerber, Jr., new Executive Secretary of the Michigan State Dental Society, was a guest.

J. H. BURLEY, M.D., *Secretary*.

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## SHIAWASSEE COUNTY

Harold Henderson, M.D., of Detroit spoke on "Analgesia and Anesthesia During Labor" at the monthly meeting of May 19 at Memorial Hospital, Owosso.

Henry J. VandenBerg, M.D., Grand Rapids, member of the Cancer Committee of the State Society, was guest speaker at the April 21 meeting at Memorial Hospital, Owosso. His subject was "Cancer."

R. J. BROWN, M.D., *Secretary*.

## WASHTENAW COUNTY

The meeting on May 11 was a joint meeting with the Oakland County Medical Society, in the Michigan Union.

Joseph Brennemann, M.D., of Chicago, was guest speaker at the meeting of April 12 in the Michigan Union. His subject was "Bronchietasis, Atelectasis, Emphysema, and Allied Conditions in Children."

W. M. BRACE, M.D., *Secretary*.

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## WAYNE COUNTY

Henry R. Carstens, M.D., was inducted as President of the Wayne County Medical Society at its annual meeting on May 16, in Detroit. Ralph H. Pino, M.D., was chosen as President-Elect, and the retiring President, Dr. C. E. Umphrey, was elected to the Board of Trustees. B. I. Johnstone, M.D., is the new Secretary. W. B. Cooksey, M.D., and R. J. Schneck, M.D., are Chairman and Secretary of the Medical Section. H. F. Dibble, M.D., and G. A. Wilson, M.D., are Chairman and Secretary of the Surgical Section.

A plaque to the memory of Dr. Arthur G. Holmes, Past-President, was unveiled by Dr. Alexander W. Blain. The twenty-five living Past-Presidents were presented with keys containing miniature gavels wrought in gold.

Dr. Umphrey was presented with a silver tea service by the general membership, the presentation being made by Dr. W. B. Harm.

The incoming President, Dr. Henry R. Carstens, was host at an "Afterglow" in the clubrooms of the W.C.M.S., following the Past-Presidents' ceremonies.

B. I. JOHNSTONE, M.D., *Secretary*.

## Cook County Graduate School of Medicine

(In affiliation with COOK COUNTY HOSPITAL)

Incorporated not for profit

Announces Continuous Courses

**MEDICINE**—Two Weeks Intensive Course starting June 20th. Electrocardiography every month. Special courses during August.

**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technic with practice on living tissue; Clinical Course; Special Courses. Courses start every Monday.

**GYNECOLOGY**—Personal Courses June 13th, August 22nd. Gynecological Pathology by Dr. Schiller starting July 25th. Two Weeks Course starting October 10th.

**OBSTETRICS**—Two Weeks Intensive Course starting October 24th. Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course; Intensive Formal Course starting October 10th.

**UROLOGY**—One Month Course; Two Weeks Course starting every two weeks.

**CYSTOSCOPY**—Ten Day Practical Course Rotary every two weeks.

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Immunize now for effective control of

# IVY DERMATITIS

PLANS FOR SPENDING summer vacations outdoors or at summer camps should include preliminary prophylactic administration of Poison Ivy Extract to avoid the risk of much misery and spoiled vacations from ivy poisoning.

Experience has shown that two small injections (1 cc. each) of "Poison Ivy Extract *Lederle*" administered a week or two apart, confer a marked degree of protection in a high percentage of cases against the distressing dermatitis which follows the usual casual, accidental contact with Poison Ivy. This protection should suffice to immunize the individual for the entire season.

In the *treatment* of ivy poisoning, "Poison Ivy Extract *Lederle*" has at times performed most spectacularly. A single injection often gives marked relief within 24 to 48 hours. A second injection 24 hours later may be required; this has an added value in its probable preventive effect in case of later exposure. A third injection is rarely necessary.

Results of Experiment in C. C. C. Camps in 1935

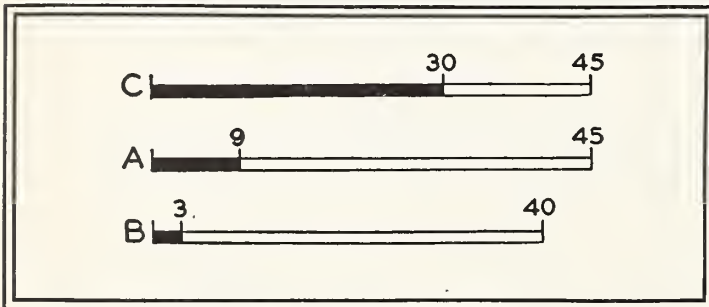


Chart shown at left covers a 6-week period following the first prophylactic dose. One hundred and thirty men were divided into three groups: A, B, C. All intermingled in their work in clearing ivy-infested areas.

*Group C received no previous injections.*

*Group A received four weekly injections of 1/12 regular dose of "Poison Ivy Extract *Lederle*."*

*Group B received four weekly injections of the regular dose of "Poison Ivy Extract *Lederle*."*

The shaded areas represent the number of exposed men affected with ivy dermatitis in the 6-week period.



For prevention and treatment

## POISON IVY EXTRACT

### *Lederle*

is stable, reliable and economical

*Packages:*

2 syringes (1 cc. each)

1 syringe (1 cc.)

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## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### SUPPLEMENT TO "CALIFORNIA STATE JOURNAL"

All Michigan Auxiliaries are interested in civic projects, centralizing their efforts around hospitals and charitable agencies that contribute to better health and the protection and education of young people.

The Battle Creek Auxiliary has provided maternity kits for nearly five hundred indigent mothers. This year they have voted to furnish a room in a new community hospital, which will necessitate raising a fund of from four to five hundred dollars. They recommend that all auxiliaries sponsor hospital sewing days.

In November the Woman's Auxiliary of Detroit was asked to present two programs in the auditorium of WWJ, *The Detroit News*. These programs were not broadcast, but the three hundred and fifty seats were filled with women from various Woman's Clubs on invitation of Sally Woodward, the originator of these Wednesday afternoon programs. Dr. B. I. Johnstone talked on "The Heart," and Dr. Frank H. Purcell "The Feet." Dr. Claire L. Straith talked on "Plastic Surgery," illustrating with lantern slides.

In March they were invited to participate in the tenth annual Child Health Institute presented by the J. L. Hudson Company. Hostesses were provided and the officers of the auxiliary presented the speakers of the day. Throughout the week hostesses for the booth maintained by the Wayne County Medical were provided. This booth contained a scientific exhibit, and displayed publications of the American Medical Association.

They have representatives on the boards of the Woman's Association of the Goodwill Industries, the Greater Detroit Motion Picture Council and the Detroit Council on Community Nursing.

The Kalamazoo Auxiliary has been taking an active interest for the past two years with the hard of hearing, and has furnished for use in that Department of the Public Schools a Fairchild Hearing Aid to assist in the teaching of voice production. Some means of tuition are also provided.

The Grand Rapids Auxiliary in collaboration with the County Society provides a benevolent fund for care of members and their dependents in distress.

Much has been accomplished in the field of Public Relations. Among the most successful were cancer lectures by Dr. Clarence Cook Little, Dr. Carl Weller of the University of Michigan and Dr. Chas. Brooks, Detroit. Dr. Morris Fishbein spoke on "Our Changing Social Order," and Dr. Robert S. Breakey on "Syphilis." Our members report that the first requirement for successful Public Relations meetings is a bureau of good speakers; secondly, both permission to hold meetings and enthusiastic sponsors. Health talks are accepted on all programs, but we cannot afford to be embarrassed because of speakers following these meetings.

The entire membership has worked diligently to increase subscriptions to *Hygeia*. It has been said by one with authority, Miss Elizabeth Camburn, speaker of note and an instructor of psychology, "*Hygeia* gives me great satisfaction in class work. It is our greatest weapon with which to battle quackery." I am confident of a substantial increase for Michigan's *Hygeia* report.

(Mrs. G. C.) BERNICE HICKS,  
State President.

### Bay County

The Auxiliary met on March 9 at the Wenonah Hotel. About twenty-five members present.

The election of new officers and chairmen for the coming year resulted as follows:

President—Mrs. R. E. Scrafford.  
Vice-President—Mrs. W. R. Ballard.  
President-elect—Mrs. A. D. Allen.  
Secretary—Mrs. Wm. G. Gamble.  
Treasurer—Mrs. R. E. Gale.  
Corresponding Secretary—Mrs. W. S. Stinson.  
Chairmen of Committees: Public Relations and Program—Mrs. W. R. Ballard; Hygeia—Mrs. A. D. Allen; Food—Mrs. L. F. Foster, Mrs. M. R. Slatery; Telephone—Mrs. Clara Ruggles.

This was the beginning of an active month. Dr. Robert S. Breakey, Lansing, came for our second Public Relations meeting. There was a demand for several times the number of tickets available. Dr. Breakey gave an unusually instructive and stirring speech, and the comments of the audience were most pleasing.

Later in the month we gave a charity bridge party in the auditorium of the Nurses' Home. This also proved a considerable success. There were about fifty tables in play. Late in the afternoon a lovely tea was served. Due to the fact that practically all the food was donated by members of the organization, our profits amounted to approximately seventy dollars. This is the second year that we have given such a party, and we now feel that we have a well established reputation for giving one of the nicest bridges in the city.

On April 13 the Auxiliary met at the home of Mrs. D. J. Mosier. Twenty-seven members had a most enjoyable pot-luck dinner, followed by a review of A. J. Cronin's "The Citadel," by Mrs. Virgil Schultz.

(Mrs. W. S.) LYNN J. STINSON,  
Corresponding Secretary.

### Eaton County

The Woman's Auxiliary of the Eaton County Medical Society met on April 21. After dinner at the Everts Cafe in Charlotte, a short business meeting was held at the home of Mrs. Sassaman. The nominating committee presented the following nominations for officers for the ensuing year:

President—Mrs. K. A. Anderson.  
Vice-President—Mrs. Sassaman.  
Secretary—Mrs. John Lawther.  
Treasurer—Mrs. D. V. Hargrave.

Each member present contributed twenty cents to be used toward a layette to be distributed where needed in the County, by the Eaton County Maternity Center. A social evening followed.

MARIAN L. HARGRAVE,  
Press Chairman, pro tem.

### Jackson County

The Women's Auxiliary held its annual election of officers Tuesday evening, April 19. The following slate was unanimously elected.

President—Mrs. R. H. Alter.  
Vice President—Mrs. Culver.  
Secretary—Mrs. J. W. Wholihan.  
Treasurer—Mrs. N. D. Wilson.

The meeting was held at the C. A. Leonard home and dinner was served by the following committee: Mesdames T. E. Hackett, chairman, W. H. Enders, G. Hicks, J. W. Speck, F. Van Schoick, E. A. Thayer and W. H. Lake.

Mrs. N. D. Wilson reported that our *Hygeia* cam-



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N. Y. State Jour. Med., 1935, 35-No. 11, 590

☐

Laryngoscope, 1935, XLV, 149-154

☐

Laryngoscope, 1937, XLVII, 58-60

☐

**SIGNED:** \_\_\_\_\_ **M. D.**

(Please write name plainly)

**ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_

MIC

paign brought us eighteen new subscriptions, eighteen renewals, and honorable mention, of which we are very proud.

Mrs. M. N. Stewart, program chairman, then introduced Miss Mary K. Pray, who read the one-act play, "One Sunday Afternoon," by James Hagan. It has become traditional with the Jackson Auxiliary that one program a year be given by members or their children. Miss Pray is the daughter of Dr. and Mrs. George George Pray, and is at present employed in the speech department of the University of Michigan.

ANNA HYDE SHAEFFER

### Kalamazoo County

Places were laid for one hundred when the Auxiliary entertained members of the Academy of Medicine at dinner April 19 at the Nurses Home, Borgess Hospital. Spring flowers decorated the tables.

Following the dinner each group held a business meeting, when Mrs. W. O. Jennings, Vice Commander of the Michigan Cancer Control Committee, gave a short report to the Auxiliary of local activities for the control of cancer which included various press items and posters, also radio talks by local members, Drs. C. E. Boys, H. R. Prentice and R. J. Hubbell, also a lecture on "Cancer" by Dr. Carl B. Weller of Ann Arbor on April 27 at the Civic Auditorium, sponsored by the Auxiliary.

A demonstration of the "Iron Lung" recently presented to the City by the Kalamazoo Foundation was especially interesting. Later the Auxiliary listened with the Academy members to the scientific lecture on "Vitamins" by Dr. Russell Hayden of Cleveland, Ohio.

On May 2, President's Day, final meeting of the Ladies Library Club, oldest federated club in Michigan, Auxiliary members occupied reciprocal places. The president, Mrs. W. E. Shackleton, was also the district organizer of the Auxiliary. The speaker was Mrs. Richard U. Light, who with her husband, Dr. Light, recently returned from a six months' airplane tour of South America and Africa, covering a 35,000-mile flight. She showed moving pictures, Cape Town to Cairo, and related many thrilling and interesting experiences.

(Mrs. Hugo) BARBARA AACH

### Kent County

The Auxiliary enjoyed a delightful afternoon, April 13, at the home of Dr. and Mrs. Leon DeVel. Our nine new members each had a pink rose to wear. We were delighted to have with us Mrs. G. C. Hicks and Mrs. J. W. Page, two of our state officers. They left a charming impression.

The business of the day included the reading and accepting of our new constitution presented by the Revision Committee with Mrs. Leon DeVel as chairman. The Auxiliary reluctantly received the resignation of Mrs. P. L. Thompson as president-elect. They did so with great regret.

Mrs. Carl Snapp, our president, left after the meeting for Mississippi. On her return May 1, she left immediately to attend the funeral of her father in South Dakota.

Due to the efforts of Mrs. William Butler and her *Hygeia* committee, Kent County Auxiliary was given honorable mention in the contest for subscriptions for *Hygeia*. Mrs. Butler, assisted by Mrs. Gert Van Houten, is now engaged in making six posters which will represent our state *Hygeia* exhibit in California at the national convention this summer. These posters depict health hygiene in various aspects of life.

The last meeting for the year was our annual

luncheon, May 11, at the Woman's City Club. Mrs. Thomas Kemmer is in charge of arrangements.

(Mrs. Robert M.) MIRIAM ADAMS EATON,  
Chairman, Press Committee

### Monroe County

The annual election of officers was held, and the following were elected:

President—Mrs. William Bond.  
Vice President—Mrs. L. C. Blakey.  
Recording Secretary—Mrs. Robt. Williams.  
Corresponding Secretary—Mrs. Claude Dusseau.  
Treasurer—Mrs. M. A. Hunter.  
Press Correspondent—Mrs. Vincent Barker.

This is our last regular meeting for the year. We will resume meetings in the fall.

(Mrs. Vincent) MARTHA BARKER

### Saginaw County

Mrs. Frederick J. Cady illustrated with motion pictures a talk on her recent Caribbean cruise before the members of the Saginaw County Medical Society and Auxiliary at the April meeting held in the home of Dr. and Mrs. Arthur E. Leitch, Saginaw.

The South Intermediate Parent-Teacher Association meeting for April was sponsored by the Public Relations Committee of the Auxiliary. Dr. Ralph Pino, of Detroit, gave an illustrated talk on "Conservation of Children's Eyesight," and Miss Erma E. Grill, a teacher at Handley school, outlined her work.

Mrs. Leitch, Mrs. Clarence E. Toshach and Mrs. Milton G. Button were named as the nominating committee for the annual election in May. Mrs. L. C. Harvie presided and Mrs. Dale E. Thomas had charge of the entertainment.

Mrs. Edwin D. MacKinnon was elected president of the Saginaw County Medical Society auxiliary at its annual luncheon Friday, at the country home of Dr. and Mrs. Keith M. Morris, Sheridan Road. Thirty-five members attended. Other new officers are: Vice president, Mrs. Robert F. Jaenichen; secretary, Mrs. Herbert C. Helmkamp; treasurer, Mrs. E. G. Hester.

The motion picture, "Behind the Shadows," shown recently before the group by Miss Thelma Cubbage of the Saginaw Tuberculosis Society, was reviewed at the business meeting conducted by Mrs. Lloyd C. Harvie.

### Wayne County

The Woman's Auxiliary has had a very interesting and varied program during the month of April. The regular meeting was held on Friday, April 8, in the club rooms of the Society. Our program chairman, Mrs. Alex Cruikshank, arranged a most appropriate spring program which centered around flowers. Professor Paul R. Krone, of the Michigan State College, spoke on "Gardens for Health" and Henry Forster made and exhibited many lovely floral arrangements which afterwards were presented to the officers of the Auxiliary. Tea was served in the lounge with Mrs. J. Whitlock Gordon and Mrs. Joseph Markay Grace as hostesses.

On April 22, the Auxiliary entertained at tea the Volunteers of the Woman's Field Army who were assisting in the soliciting of funds for the control of cancer. Presiding at the tea table were Mrs. James H. Dempster, Mrs. Guy L. Kiefer, Mrs. Roger V. Walker, and Mrs. Clarence E. Umphrey.

Mrs. H. Wellington Yates, chairman of the Public Relations Committee, sponsored a lecture on "Cancer" given by Dr. Carl V. Weller of the University of Michigan, in the ballroom of the Hotel Statler. Preceding the lecture a luncheon was held in one of the smaller rooms. This lecture was open to the public and Dr. Weller gave a most impressive talk explaining the nature, causes, symptoms, and treatment of the disease.

HELEN R. DOUB, Press Chairman





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This kit affords the physician a **SAFE**, sterile field for his home deliveries. It is **SIMPLE**, **COMPACT** and **EFFICIENT**. A thermo-aseptic indicator assures its sterility. Remember—specify the **INGA O.B. KIT**.

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# MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

Federation of Labor; R. A. Broadbent, Michigan Pharmaceutical Association; Dr. U. G. Rickert, president, Michigan State Dental Society; Charles Winegar, Detroit; Harry J. Kelley, Grand Rapids; Ray Baartz, Detroit Council of Social Agencies, and George F. Granger of the Michigan ERA.

The first organization meeting of the committee was held May 4 in Lansing.

\* \* \*

## HEALTH CONSERVATION CONTEST

Municipal health departments of Detroit, Grand Rapids and Saginaw received high honors in the annual city health conservation contest sponsored by the Chamber of Commerce of the United States in cooperation with the American Public Health Association.

The Grand Rapids Health Department, directed by Dr. John Lavan, and the Saginaw Health Department, directed by Dr. Frank Poole, were given awards of merit in their respective classifications. The Detroit Health Department, under the direction of Dr. Henry F. Vaughan, received a special award for maintaining previous high standards of health services among cities having won first place two or more times and are therefore barred from the regular contest. In the first contest sponsored by the A.P.H.A. for the most effective community-wide programs for tuberculosis control, Detroit also was awarded highest honors among the competing municipal health departments.

In the rural health conservation contest financed by the W. K. Kellogg Foundation, the Saginaw County Health Department, directed by Dr. V. K. Volk, the Ottawa County Health Department, directed by Dr. Ralph TenHave, and the Mecosta-Osceola Health Department, directed by Dr. M. C. Igloe, took three of the six awards of merit made to the competing rural health departments in the Northeastern Division.

These awards are not made for the healthiest cities and counties, but they are prizes for the most effective efforts to meet local health problems. Not only the health department program but the community-wide efforts of all agencies and groups including practitioners of medicine and dentistry are considered in determining the annual awards.

Some of the activities considered in making the awards are: The extent to which the water supply is protected; satisfactory sewage disposal and rural sanitation; the safety of the milk supply; adequate care of prenatal cases; medical supervision of infants; the availability of well trained nursing service; the degree in which local physicians and dentists aid in the public health program; and the activities to control tuberculosis and syphilis.

There were 241 United States entries and thirty-five Canadian entries in the rural contest, and 263 municipal health departments were entered in the 1937 city health conservation contest.

\* \* \*

## SEROLOGIC TESTS ON MARRIAGE LICENSE APPLICANTS

Slightly more than one per cent of the 9,682 persons given serologic tests by the laboratories of the Michigan Department of Health as required by Michigan's Antenuptial Physical Examination Law have shown positive indications of syphilis since the act became effective last November.

A total of 125 positive and nineteen doubtful serologic tests for syphilis have been reported by the Bureau of Laboratories in the five months ending March 31. Private laboratories registered by the Department reported during the same period a total of 111 positive and two doubtful reactions. No

## RECOMMENDED IMMUNIZATION SCHEDULE

The Michigan Department of Health is cooperating with the Michigan State Medical Society and the Academy of Pediatrics (Michigan Branch) in the promotion and application of a common schedule for immunizing children against the various communicable diseases. The schedule adopted represents the best available information regarding immunization procedures.

The Department has prepared desk cards embodying the recommendations of the committee to be mailed to every physician through the courtesy of the Michigan State Medical Society. These recommended immunization procedures will be promoted by the staff of the Michigan Department of Health and recommended in the various Department publications. Local health officers will also be urged to promote the recommended schedule. The desk card mailed to physicians carried the following information:

### FOR YOUR DESK AN IMMUNIZATION SCHEDULE

Approved by  
Academy of Pediatrics (Michigan Branch)  
Michigan State Medical Society  
Michigan Department of Health

AT 3 TO 6 MONTHS.....PERTUSSIS  
(Optional)  
AT 9 MONTHS.....DIPHTHERIA  
(Alum precipitated toxoid, two doses one month apart, administered subcutaneously just under the skin—not intramuscularly.)  
AT OR BEFORE 12 MONTHS.....VACCINATION  
FOR SMALLPOX  
DO SCHICK TEST six to twelve months after last dose of  
Toxoid to insure immunity from diphtheria.  
NOTE—It is very important to keep above biologicals  
under refrigeration. Watch expiration date. Sauer's Pertussis Vaccine must be kept on ice continuously.  
DO A TUBERCULIN TEST AT 3, 6, 9, 12 AND 15  
YEARS.  
THE USE OF IODIZED SALT IS ADVISABLE.

As a follow-up to the immunization schedule the committee is preparing detailed outlines of recommended procedures in immunizations for smallpox, diphtheria and pertussis. These outlines will also be sent to practitioners.

\* \* \*

## GOVERNOR APPOINTS MEDICAL SURVEY COMMITTEE

Governor Frank Murphy has appointed a committee to make a state-wide survey of the medical needs of medically indigent families. The extent of medical needs of welfare, old age assistance and WPA beneficiaries, the inequalities in the distribution of medical care, and the legal obstacles to meeting these needs will be studied by the Governor's committee.

The committee will offer every assistance possible to the Michigan State Medical Society, which is conducting a similar survey.

Members of the Governor's committee include Dr. Don W. Gudakunst, State Commissioner of Health; James G. Bryant, State Welfare Director; Nelle Williams, Old Age Assistance Bureau; Dr. Ralph Pino, Detroit; Dr. Paul Kniskern, medical director, Kent County ERA; Dr. R. G. Tuck, medical director, Oakland County ERA; A. N. Hennigar, Detroit Board of Education; John Reid, secretary, Michigan



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(A CORPORATION NOT FOR PROFIT)

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The Chicago Tumor Institute offers consultation service to physicians in the diagnosis and treatment of cancer and radiation facilities for cancer patients.

The Institute also conducts research and offers training to physicians who may wish to qualify as specialists in the study and treatment of this disease.

Indigent patients amenable to radiation therapy will be accepted without charge.

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record is available of the total number of examinations performed by the registered laboratories.

Although the Department laboratories during March made the largest number of serologic tests for marriage license applicants since the law became effective, the number of positive reactions was the lowest, averaging less than one per cent. There were eighteen positive and six doubtful reactions among the 2,145 persons examined.

The Bureau of Records and Statistics reports that marriages during the last quarter of 1937 when the law went into effect totaled 10,628 compared with 12,282 in the same period of 1936 and 11,484 in 1935. There were 5,404 licenses granted in October, the last month under the old law. This total then dropped to 3,433 in November with a still further decline in December to 1,791. Since that low point marriages have tended to approach their former levels as a greater popular understanding of the purposes of the new law has been brought about.

\* \* \*

### OBSTETRICS TRAINING AT UNIVERSITY HOSPITAL

Physicians of Northern Michigan and the Upper Peninsula are being offered an opportunity to attend the University of Michigan for two weeks of intensive postgraduate work in obstetrics under the supervision of Dr. Norman F. Miller, head of the Department of Obstetrics and Gynecology, it has been announced by the Bureau of Maternal and Child Health.

The two physicians selected to attend each fortnightly session will be given the personal attention of Dr. Miller and his staff, and the extensive facilities of University Hospital will be made available for their use. The training will include observation of all obstetrical cases, including many abnormal cases, work in the antepartum and postpartum clinics, participation in staff meetings and discussions, supervised work in the endocrinology clinic and instruction in connection with the University's outstanding cancer clinic.

This opportunity for intensive postgraduate training in obstetrics has been arranged through the cooperation of Dr. Miller, Dr. James D. Bruce, vice president and director of postgraduate medicine at the University, and the Michigan State Medical Society. The course is being financed with funds allotted to the Michigan Department of Health under the maternal and child health provisions of the Social Security Act.

Physicians who will attend the course for two-week periods between April 18 and June 25 include the following: Dr. C. G. Porter, Traverse City; Dr. W. H. Mast, Petoskey; Dr. G. B. Saltonstall, Charlevoix; Dr. C. G. Clippert, Grayling; Dr. B. A. Holm, Cadillac; Dr. M. R. Murphy, Cadillac; Dr. R. W. Albi, Lake City; Dr. H. F. Mullenmeister, Bear Lake; and Dr. E. C. Hansen, Manistee.

The course will be continued indefinitely as long as there is a demand for this type of obstetrical training.

\* \* \*

### AUTOMOBILE DEATHS DECLINE

Automobile deaths declined 47 per cent in March this year compared with 1937 figures, according to a report by the Bureau of Records and Statistics. A similar encouraging decline has been noted throughout the entire first quarter of 1938.

There were 78 deaths caused by automobiles in March this year compared with 147 last year. During the first quarter 255 deaths were reported in contrast to the total of 461 during the same period in 1937.

In an analysis of the 2,175 automobile deaths

recorded in 1937, the Bureau reported that 76.8 per cent of the persons killed were males and 23.2 per cent females. Of the 1,670 male deaths, the greatest number, 201, occurred in the age group 20 to 24. The greatest number of female deaths also occurred in this age group—47 of the total of 505.

Seventy of the total deaths occurred in the age group under five, 83 in the age group five to nine, 87 in the age group 10 to 14, and 168 in the age group 15 to 19. The second highest mortality for any age group occurred in the 45 to 49 group, where 179 deaths were reported. A total of 51 persons aged eighty and above was killed by automobiles in 1937.

\* \* \*

#### AN IMMUNIZATION SCHEDULE

Approved by  
Academy of Pediatrics (Michigan Branch)  
Michigan State Medical Society  
Michigan State Board of Health

AT 3 TO 6 MONTHS.....PERTUSIS  
Optional.

AT 9 MONTHS.....DIPHTHERIA  
Alum Ppt. Toxoid, two doses one month apart,  
administered subcutaneously—just under the skin—  
not intramuscularly.

AT OR BEFORE 12 MONTHS.....  
VACCINATION FOR SMALLPOX

DO SHICK TEST six to twelve months after last  
dose of Toxoid to insure immunity from diphtheria.

NOTE—It is very important to keep above biologicals under refrigeration. Watch expiration date. Sauer's Pertussis Vaccine must be kept on ice continuously.

DO A TUBERCULIN TEST AT 3, 6, 9, 12, AND  
15 YEARS.

The use of IODIZED SALT is advisable.

Details in procedures will follow.

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# CHICAGO



## ◆ General News and Announcements ◆

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1. Barry County Medical Society.
2. Cass County Medical Society.
3. Chippewa-Mackinac County Medical Society.
4. Clinton County Medical Society.
5. Delta County Medical Society.
6. Dickinson-Iron County Medical Society.
7. Eaton County Medical Society.
8. Gogebic County Medical Society.
9. Hillsdale County Medical Society.
10. Houghton-Baraga-Keweenaw County Medical Society.
11. Ingham County Medical Society.
12. Jackson County Medical Society.
13. Lapeer County Medical Society.
14. Lenawee County Medical Society.
15. Livingston County Medical Society.
16. Luce County Medical Society.
17. Manistee County Medical Society.
18. Mecosta-Osceola County Medical Society.
19. Menominee County Medical Society.
20. Muskegon County Medical Society.
21. Newaygo County Medical Society.
22. O.M.C.O.R.O. County Medical Society.
23. Oceana County Medical Society.
24. Ontonagon County Medical Society.
25. Saginaw County Medical Society.
26. St. Clair County Medical Society.
27. Schoolcraft County Medical Society.
28. Shiawassee County Medical Society.
29. Tuscola County Medical Society.

These county medical societies have recorded 100 per cent paid membership for the year 1938. Is your county society listed above? Several societies have reported dues for all their members except one or two. If your dues are unpaid, please contact your county secretary today; you may be able to put your society in the 100 per cent classification.

*Dr. Ralph Wadley* of Lansing spoke before the Livingston County Medical Society in Howell on May 6. His subject was "Surgery of the Abdomen."

\* \* \*

*Dr. R. G. B. Marsh*, Tecumseh, spoke before the Tecumseh Rotary Club on May 10. His subject was "The History of Medicine."

\* \* \*

*You owe much* of your medical security today to the past activities of organized medicine. Help carry on!

\* \* \*

*Dr. L. Byron Ashley* of Detroit discussed "Cancer of the Large Bowel," Diagnosis and Treatment" before the Sanilac County Medical Society at Port Huron, Michigan, May 3.

\* \* \*

*Preventive Medicine* was the key-note of the 23rd Annual Meeting of the American Association of Industrial Physicians and Surgeons held in Chicago, June 6, 7, 8 and 9.

\* \* \*

*Dr. Harold R. Roehm* of Pontiac has been appointed to the Syphilis Control Committee of the Michigan State Medical Society by President Henry Cook.

\* \* \*

*Patronize those who support you.* Ask all detail men who call upon you, seeking your patronage, "Does your firm advertise in THE JOURNAL of the Michigan State Medical Society?"

*The Court of Appeals* of the State of New York has handed down an opinion in the case of Bennett vs. Layman that a court may enjoin a chiropractor from practicing medicine.

\* \* \*

*A graduate course in electrocardiography* will be given for two weeks beginning August 22 at Michael Reese Hospital, Chicago. For further information write the Medical Librarian, 29th and Ellis Ave., Chicago, Ill.

\* \* \*

*Upper Peninsula Medical Society meeting*, Sault Ste. Marie, August 17, 18, 1938. Present plans call for a morning session on "The Socio-economic Problems of Medicine" as well as a symposium on Preventive Medicine.

\* \* \*

*Be Safe.* Protect your patients and your reputation. Prescribe only tested drugs, accepted by the Council of the American Medical Association. No unproven drugs are advertised in THE JOURNAL of the Michigan State Medical Society. Consult your JOURNAL.

\* \* \*

*Loren W. Shaffer, M.D.*, chairman of the State Society's Syphilis Control Committee, delivered a paper at the annual meeting of the Michigan Pharmaceutical Association in Lansing on June 8. The subject of his address was "The Druggist's Role in Our Syphilis Control Program."

\* \* \*

*New constitutions and by-laws*, developed in accordance with the Model Constitution and By-Laws recommended by the Michigan State Medical Society, were adopted by the Huron-Sanilac County Medical Society on April 21, and by the Lapeer County Medical Society on April 29.

\* \* \*

*A summer camp for boys* with impaired hearing is conducted every summer at Clearwater Lake, Deerwood, Minnesota. "Lang Craft" is the name of this unusual camp located 115 miles north of Minneapolis. For information write V. A. Becker, Kendall Green, Washington, D. C.

\* \* \*

*Dr. D. R. Brasie* of Flint was elected secretary at the meeting of the Northern Tri-State Medical Association in Findlay, Ohio, on April 12. Drs. H. E. Randall and W. H. Marshall of Flint were chosen as councilors. The next meeting will be held in South Bend, Indiana, in April, 1939.

\* \* \*

*The American Congress of Physical Therapy* will conduct an intensive didactic and clinical course in physical therapy at the Palmer House in Chicago, September 7, 8, 9 and 10, 1938. This will precede its annual convention of September 12, 13, 14 and 15. For further information write 30 N. Michigan Avenue, Chicago.

\* \* \*

*Design for Distinction:* Doctors of medicine should be careful to publish "M.D." rather than "Dr." on their signs, their stationery, and in their correspondence. Nowadays, anyone calls himself "Doctor." Physicians should distinguish between "Dr." and "M.D." the latter being a distinction and a privilege.

*The Providence Hospital (Detroit) Interne Alumni Association* held its Annual Spring Clinic on May 11 and 12. Among the guest speakers were George H. Thiele, M.D., of Kansas City; J. Grafton Love, M.D., of Rochester, Minn.; Hugh Young, M.D., of Baltimore, Md.; and Martin Batts, M.D., of Ann Arbor.

\* \* \*

*Dr. G. C. Stucky*, who for thirteen years has been superintendent of the Ingham County Tuberculosis Sanatorium at Lansing, recently resigned his post to accept a position with the W. K. Kellogg Foundation in Battle Creek. Dr. Stucky will work on a rural health project being conducted in seven counties by the Kellogg Foundation.

\* \* \*

*Dr. E. G. McGavran* of Hillsdale, Dr. E. D. Spaulding of Detroit, and Executive-Secretary Wm. J. Burns were members of the panel on Nursing Legislation, held in Battle Creek, May 12, as part of the program of the annual meeting of the Michigan State Nurses Association.

\* \* \*

*Dates to remember:*

*September 13, 1938*, General Primary Election;

*October, 19, 1938*, last date for registration prior to general November election;

*November 5, 1938*, last day applications for Absent Voter's Ballot for general election may be received;

*November 8, 1938*, general November election.

\* \* \*

*The Glee Club* of the Wayne County Medical Society, which presented its very successful Fifth Annual Concert at the Detroit Institute of Art on April 25, has been invited to present several selections on the occasion of the annual meeting of the Michigan State Medical Society, Book-Cadillac Hotel, Detroit, September 19, 20, 21 and 22.

\* \* \*

*Drs. J. D. Brook* of Grandville and *H. A. Luce* of Detroit have been honored by the American Medical Association. Dr. Brook has been chosen as chairman of the Committee on Executive Sessions, and Dr. Luce has been selected as chairman of the Committee on Constitution and By-Laws, for the San Francisco session of the House of Delegates, A.M.A. Congratulations!

\* \* \*

*Medical Mayors.*—The recent elections in various localities of Michigan resulted in a number of Doctors of Medicine being elected mayors of their cities. Information received to date includes: (1) Dr. T. E. DeGurse, Marine City; (2) Dr. F. B. Carney, St. Clair; (3) Dr. A. R. Miller, Harrisville; (4) Dr. A. G. Sheets, Eaton Rapids; (5) Dr. B. H. VanLeuven, Petoskey. Congratulations!

\* \* \*

*Raymond Moley*, in *News Week* of March 14, writes: "There is in this country a tradition of contempt for the capabilities of government summed up in the venerable 'Least governed, best governed.' This tolerant cynicism has grown by what it has fed upon—the frequently demonstrated inefficiency and incompetence of local, state and federal administrations in the past."

\* \* \*

*Incorporators of the Michigan Health League* are: L. G. Christian, M.D., Lansing; T. K. Gruber, M.D., Eloise; R. G. Tuck, M.D., Pontiac; G. E. Madison, D.D.S., Detroit; W. O. Roeser, D.D.S., Pontiac; O. W. White, D.D.S., Detroit; Emily Sargent, R.N., Detroit; Olive Sewell, R.N., Lansing; Marian Durell, R.N., Ann Arbor; Otis Cook, Lansing; Sam Dunseith, Pontiac; J. Howard Hurd, Flint.

JUNE, 1938



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The Detroit Tigers will be at home in Detroit prior to, during and immediately following the 1938 annual meeting of the Michigan State Medical Society next September:

September 15, 16, 17—playing New York.

September 18, 19—playing Washington.

September 20, 21—playing Philadelphia.

September 22, 23, 24, 25—playing Cleveland.

\* \* \*

"Guide to Medical Facilities in Wayne County, Michigan" is the title of an article which appears in *The Journal of the A.M.A.*, May 21 issue, page 213 (Bulletin Section). This reprints the diagram developed by the Medical Economics Commission of the W.C.M.S., listing the various facilities for the care of all types of patients in Detroit and Wayne County, which is a pioneer, monumental work.

\* \* \*

Officers and committeemen of the Michigan State Medical Society, guests at the Ingham County Medical Society's "State Society Night" on Tuesday, May 17, included: Drs Henry Cook, L. Fernald Foster, P. R. Urmston, Wm. A. Hyland, James H. Dempster, Henry E. Perry, A. L. Callery, T. F. Heavenrich, R. S. Dixon, L. W. Shaffer, John Lavan, V. M. Moore, Reuben Maurits, R. H. Holmes, and Executive Secretary Wm. J. Burns.

\* \* \*

"What Everyone Should Know About Cancer" is the title of the new booklet prepared by the Cancer Committee and published by the Michigan State Medical Society, as of June, 1938. This booklet covering sixteen phases of Cancer, one to a page, has been mailed to all members of the Michigan State Medical Society. Additional copies are available by writing the Executive Office, 2020 Olds Tower, Lansing. The booklets are supplied with the compliments of the State Society.

\* \* \*

An experienced casualty insurance executive stresses an important matter regarding malpractice and personal liability insurance. He says that policies embracing these two kinds of coverage should be retained indefinitely, because a minor can sue for damages anytime within two years after attaining his majority. The policy in force at the time a child was injured is a very important document to have on hand if a suit is started against you by him in later years.

\* \* \*

The Monroe County Medical Society sponsored a "State Society Night" at the Monroe Country Club on Thursday, May 19. The program included addresses by Secretary L. Fernald Foster, Bay City; Councilor Howard H. Cummings, Ann Arbor; Council Chairman P. R. Urmston of Bay City, and Executive Secretary Wm. J. Burns. A 100 per cent attendance of the society's membership was registered. The meeting was arranged by President W. J. Gelhaus and Secretary Florence Ames.

\* \* \*

The Ingham County Medical Society's Bulletin of May, 1938, was a special number dedicated to "State Society Night" held in the Olds Hotel, Lansing on May 17. This issue also printed the scientific papers delivered at the Ingham County Medical Society's Annual Clinic of April 28.

This edition of 44 pages was a credit to the very active Ingham County Medical Society and to its editors, Drs. H. C. Rockwell, Frank C. Troost, K. H. Johnson, Perry Spencer.

Dr. C. H. Baker of Bay City, president of the Michigan State Medical Society in 1919, was honored by the Bay County Medical Society at its meeting of May 25. Life membership in the county society was accorded Dr. Baker. Members of Dr. Baker's official family during his presidency of the Michigan State Medical Society, as well as the present officers and councilors of the State Society, were honored guests at the meeting in the Winonah Hotel at which some two hundred physicians and other civic leaders of Bay City were present.

\* \* \*

*Notice to secretaries of county medical societies:* The Executive Committee of The Council requests all county medical societies to certify the names of members for whom Honorary or Retired or Emeritus or Associate Membership in the State Society will be sought next September, to the Executive Office, 2020 Olds Tower, Lansing, thirty days in advance of the annual meeting. The name of any physician, to be recommended by his county medical society to the House of Delegates, should be certified to the Lansing office not later than August 19, 1938, in order that the records may be checked.

\* \* \*

*The problem of medical economics* is not only one of the most important before the medical profession today; it is also one of the most difficult. To analyze the present intricate and confused situation in the field of medicine, to execute studies which will point the way to more efficient service for all the people, and to formulate wise recommendations on the basis of the facts revealed by the studies require ability of high order. The wise and far-seeing Disraeli reflected this understanding when he said: "Public health is the foundation on which reposes the happiness of a people and the power of a country."

\* \* \*

*New advertisers* in the May Number of THE JOURNAL of the Michigan State Medical Society were:

1. American Association of Industrial Physicians & Surgeons, Chicago, Ill.
2. The J. H. Eastman Company, Detroit, Michigan.
3. Employers Mutual Liability Company, Wausau, Wis.
4. Ford Motor Company, Dearborn, Michigan.
5. R. L. McCabe, Detroit, Michigan.
6. National Pathological Laboratories, Detroit, Michigan.
7. Wm. B. O'Donnell, Inc., Detroit, Michigan.
8. Physicians Equipment Exchange, Detroit, Michigan.
9. Randolph Surgical Supply Company, Detroit, Michigan.
10. Rouser Drug Company, Lansing, Michigan.
11. Uehmann Optical Company, Detroit, Michigan.
12. David Whitney Building, Detroit, Michigan.

\* \* \*

#### Dr. William H. Marshall Honored

Dr. William H. Marshall, dean of Flint physicians, has been honored by the medical staff of Hurley Hospital with the honorary title of director emeritus of internal medicine. This title has been given in recognition of Dr. Marshall's work in teaching internal medicine to younger physicians.

The following is the resolution adopted by the hospital staff:

"Whereas, Dr. William H. Marshall, through many active years, has been connected with the staff of Hurley Hospital, and in his capacity has greatly influenced the lives of all who have come in contact with him, and

"Whereas, this staff desires to express the deep appreciation of his influence and unselfish services,

"Be it resolved, that we, the staff, unanimously confer upon Dr. William H. Marshall the title of Director Emeritus of the Department of Internal Medicine of Hurley Hospital."

The Editor of THE JOURNAL of the Michigan State Medical Society, extends congratulations.

JUNE, 1938

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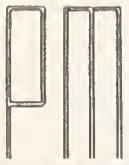
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The first annual case report contest for junior internes was recently sponsored by the East Side Physicians Association of Detroit. This commendable contest is the first competition of its kind, in Michigan. As the *Detroit Medical News* states: "Its value in stimulating good case reporting among internes is inestimable, and is a constructive project worthy of wide emulation." The internes whose papers achieved first, second and third places were presented with their awards through the Wayne County Medical Society at its meeting of May 2. The winners of the awards were Alice E. Palmer, Robert M. Trapp and Harold A. Ott, all of Detroit.

\* \* \*

*Afflicted and Chrippled Children Commitments* in April, 1938, were as follows: Crippled Children: Total cases, 331, of which 99 went to University Hospital and 232 went to miscellaneous hospitals. Of the above, Wayne County sent 77 to hospitals, of which 9 went to University Hospital and 68 went to miscellaneous hospitals.

Afflicted Children: Total cases, 1,826 of which 213 went to University Hospital and 1,613 went to miscellaneous hospitals. Of the above, Wayne County sent 514 to hospitals, of which 40 went to University Hospital and 474 went to miscellaneous hospitals.

\* \* \*

Wayne S. Ramsey, M.D., past president of the Washtenaw County Medical Society (1932), is the new secretary-treasurer of the Michigan Crippled Children Commission. Dr. Ramsey was graduated from Harvard Medical School in 1912 and practiced pediatrics in Ann Arbor for ten years, beginning in 1926. In 1936 he returned to Harvard for postgraduate work in public health. From February 1, 1937, to May 1, 1938, he was Director of Maternal and Child Health in the State Department of Public Health in Pennsylvania. Dr. Ramsey's hobbies are child health and baseball (he is an old baseball player).

\* \* \*

*Who wants socialized medicine?* The patient does not, because he doesn't want any meddling third party to come between him and his physician. For example, in workmen's compensation cases, the pinch-penny insurance company which interrupts this satisfactory, personal relationship and rides rough-shod over the rights of both patient and family physician, is the type of meddler the patient resents.

The patient doesn't want to suffer delay in treatment due to numerous bureaus and agencies to which he must apply, even after he has paid in his share of taxes or insurance premiums. Such an inhuman system is not applicable to the ways of a free and independent people guaranteed life, liberty, and pursuit of happiness.

\* \* \*

*Midwifery* is the practice of medicine and those engaged therein must be licensed by the Michigan State Board of Registration in Medicine, is the ruling of Recorder's Court Judge John J. Mahar in the case of Mrs. Nellie Hildy, decided Tuesday, April 26. The Wayne County Prosecutor's Office is to be complimented for its presentation of the facts in this case. Among interesting data educed at the trial was the fact that during the year 1935 less than 1 per cent (223) of the total number of children born in Detroit were delivered by the city's twenty-five midwives. One hundred and thirty of these were handled by two midwives. On the other hand, twenty-five years ago, one-third of all births in the city were so attended.—*Detroit Medical News* of May 9, 1938.

**Blind and Deaf Children:** The educational program in the State for both the blind and the deaf groups is greatly handicapped by lack of an early census of these children. In order to be of service to the parents of the blind child in preventing "blindness" and queer personality developments, the State Department of Public Instruction wishes to be informed of each child at the earliest possible moment. In the case of the deaf, diagnosis is of course more difficult, but special training should be started in the home as early as three years of age. Otherwise these children grow up to school age without having developed any conception of language. A system of reporting the blind and the deaf children on identification is a highly desirable service. Please supply the names of such cases to your local school authorities, or to the State Department of Public Instruction, Lansing.

\* \* \*

**A Public Relations Committee meeting** with secretaries of County Medical Societies in the Upper Peninsula, was held Sunday, May 15, 1938. The subject was "The A.M.A. Survey." Those present were: Drs. L. A. Berg, Menominee; F. J. Dewane, Menominee; W. S. Jones, Menominee; David Littlejohn, Sault St. Marie; V. H. Vandeventer, Ishpeming; Simon Levin, Houghton; A. B. Aldrich, Houghton; W. H. Alexander, Iron Mountain; C. E. Merritt, Iron Mountain; W. H. Huron, Iron Mountain; D. P. Hornbogen, Marquette; N. J. McCann, Marquette; M. Cooperstock, Marquette; C. D. Hart, Newberry; C. A. Cooper, Hancock; W. A. Manthei, Lake Linden; F. C. Bandy, Sault St. Marie; W. A. Lemire, Escanaba; G. W. Benson, Escanaba; L. Fernald Foster, Bay City; and Executive Secretary Wm. J. Burns, Lansing.

\* \* \*

**Detroit is the winner** in the Tuberculosis Control Contest which is part of the City Health Conservation Contest conducted annually by the Chamber of Commerce of the United States in coöperation with the American Public Health Association. A few of the items considered by the committee were: The comprehensiveness of case-finding and follow-up services in connection with tuberculosis and syphilis, the facilities provided for diagnostic and treatment purposes, and the extent of group participation in programs of education and control.

Grand Rapids, Michigan, and Saginaw, Michigan, were winners in the Ninth Annual City Health Contest. Detroit, which has twice won the honor as "Healthiest City" in its respective population group (and is therefore barred from the regular contest), was given a Special Award this year as having maintained during 1937 its previous high standards of health protection service. The 1937 contest had 263 entries.

"The Management of the Septic Patient with Otitis Media" is the title of a paper published in *The Journal of the A.M.A.* of May 7, by J. H. Maxwell, M.D., Ann Arbor.

To the same issue of *The Journal*, Carey P. McCord, M.D., Detroit, Edwin E. Teal, M.S., Ann Arbor, and Wm. N. Witheridge, M.S., Detroit, contributed an article on "Noise and Its Effect on Human Beings; Noise Control as a By-Product of Air Conditioning."

"Actinomycotic Meningitis with a Primary Focus in the Finger," by D. B. Morrison, M.D., Tekonsha, and A. A. Humphrey, M.D., and James E. Bailey, M.D., of Battle Creek, also appears in this number of *The Journal of the A.M.A.*

In the April 30 issue of *The Journal of the A.M.A.* are articles by two Michigan physicians: "Emergency Treatment in Asthma" by Geo. L. Waldbott, M.D., Detroit; and "Subcutaneous Rupture of the Jejunum Sustained in a Game of Football" by W. H. Ulrich, M.D., J. E. Webster, M.D., and C. Fremond Vale, M.D., of Detroit.

"Continuing Professional Education" by James D. Bruce, M.D., Ann Arbor, is an article in the April 23 issue of *The Journal of the A.M.A.*

\* \* \*

### Wayne County Medical Society

The final meeting of the Wayne County Medical Society for the spring term was held on May 16. A feature of the evening was the unveiling of a memorial plaque to the late Dr. Arthur D. Holmes. Dr. Holmes was one of the pioneer members of the Wayne County Medical Society as now constituted and was prime mover in the purchase and establishment of the first Wayne County Medical Club Rooms on High Street. Appropriate addresses were made by Dr. Alexander W. Blain, chairman of the board of trustees, and others. Dr. H. R. Carstens, who is now president of the Wayne County Medical Society, gave his inaugural address and a recessional address was made by Dr. C. E. Umphrey, the retiring president. Dr. Umphrey was presented with a silver tea service.

A feature of the evening was the presentation of honorary gavels to the living past presidents of the society. A response was made by Dr. Angus McLean. The past presidents, with the dates of service, are as follows:

O. S. Armstrong, M.D. (1892-93); A.N. Collins, M.D. (1907-08); Angus McLean, M.D. (1910-11); L. J. Hirschman, M.D. (1913-14); Don M. Campbell, M.D. (1914-15); W. L. Babcock, M.D. (1917-18); John N. Bell, M.D. (1918-19); James E. Davis, M.D. (1921-22); Wm. M. Donald, M.D. (1922-23); Frank A. Kelly, M.D. (1923-24); Wm. J. Stapleton, Jr., M.D. (1924-25); H. A. Luce, M.D. (1925-26); J. H. Dempster, M.D. (1926-27); G. V. Brown, M.D. (1927-28); E. G. Martin, M.D. (1928-29); A. S. Brunk, M.D. (1929-30); J. M. Robb, M.D. (1930-31); H. W. Plaggenmeyer, M.D. (1931-32); H. W. Yates, M.D. (1932-33); A. W. Blain, M.D. (1933-34); Wm. J. Cassidy, M.D. (1934-35); R. C. Jamieson, M.D. (1935-36); T. K. Gruber, M.D. (1936-37).

**Organization talks** by officers and by the executive secretary of the Michigan State Medical Society during the past month include:

Speaker	Date	City	Organization	Subject
Wm. J. Burns	5/6	Howell	Livingston County Medical Soc.	"A.M.A. Survey"
Wilfrid Haughey, M.D.	5/11	Coldwater	Branch-St. Joseph Medical Soc.	"State Society Night"
F. C. Bandy, M.D.	5/15	Marquette	U.P. Secretaries' Conference	"A.M.A. Survey"
W. A. Manthei, M.D.	5/15	Marquette	U.P. Secretaries' Conference	"Coöperation"
Henry Cook, M.D., et al	5/17	Lansing	Ingham County Medical Society	"State Society Night" on "Syphilis Control"
Bruce Douglas, M.D.	5/17	Adrian	Lenawee County Medical Soc.	"Tuberculosis"
Fred Miner, M.D.	5/17	Adrian	Lenawee County Medical Soc.	"A.M.A. Survey"
H. H. Cummings, M.D.	5/17	Adrian	Lenawee County Medical Soc.	"Society Activities"
Fred Miner, M.D.	5/17	Ann Arbor	Washtenaw County Medical Soc.	"A.M.A. Survey"
P. R. Urmston, M.D.	5/19	Monroe	Monroe County Medical Society	"Work of The Council"
H. H. Cummings, M.D.	5/19	Monroe	Monroe County Medical Society	"Postgraduate Opportunities"
Henry Cook, M.D., et al	5/24	Bay City	Bay County Medical Society	Ceremonies for M.S.M.S. Past-President, C. H. Baker, M.D.



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The "State Society Night" arranged by the O.M.C.O.R.O. County Medical Society at the Gaylord Sanitarium on April 27 was in the nature of a symposium on tuberculosis. Dr. Bruce H. Douglas, Detroit, Chairman of the M.S.M.S. Committee on Tuberculosis Control, spoke on "Case-finding in Tuberculosis." Dr. W. M. Tuttle of Detroit spoke on "Surgical Treatment of Pulmonary Tuberculosis." Those present at this inaugural medical meeting at the new sanitarium were: Drs. Henry Cook, P. R. Urmston, L. Fernald Foster, B. H. VanLeuven, C. R. Keyport, Bruce Douglas, J. C. MacPhail, C. L. Hess, T. R. Laughbaum, A. C. MacKinnon, F. W. Lee, H. J. Whitfield, Charles Katz, J. L. Egle, Vito Guardalabene, E. A. Hier, D. L. Quinn, E. S. Parmenter, R. O. Ford, R. W. Albi, J. H. McColl, F. Pitkin Husted, F. F. Grillet, W. H. Mast, J. G. Zimmerman, G. A. Holliday, F. G. Swartz, O. F. Jens, G. E. Frank, D. C. Burns, S. A. Stealy, M. A. Martzowka, W. B. Newton, Otto von Renner, R. C. Peckham, G. L. McKillop, H. M. Jardine, J. A. Keho, J. T. Jerome, M. F. Osterlin, T. Wienczewski, F. J. O'Donnell, R. H. Robbins, R. J. Beeby, E. A. Wittwer, J. C. Grosjean, G. M. Brown, W. M. Tuttle, Sue H. Thompson, Miss Bessie Pearsall, Mrs. E. S. Parmenter, V. L. Dunklin, D.D.S., and Executive Secretary Wm. J. Burns.

\* \* \*

The Joint Committee on Health Education held its annual meeting in Ann Arbor, Thursday, June 2. Burton R. Corbus, M.D., Grand Rapids, chairman, reviewed the history of the committee from the time of its inception in 1921 by members of the Michigan State Medical Society in coöperation with the University of Michigan.

The reports of the committee and the field secretary indicated the healthy period of activity during 1937-38. Three major committees of the Michigan State Medical Society received benefit directly from this organization. The Cancer, Syphilis and Radio Committees, each with programs designed to present authentic medical information to the laity, have found the Joint Committee useful and effective in presenting their programs to the public. This year, 72 lectures on the subject of "Cancer" and 38 on "Syphilis" were scheduled and given before public and professional groups. In addition, a series of 24 weekly broadcasts on medical subjects was conducted over eleven radio stations in the state under the direction of Fred A. Cole, M.D., chairman of the Radio Committee. This program was made possible through the facilities of the Joint Committee.

Even though lectures and the radio are important channels for the dissemination of authentic medical information which concerns personal and community health, reaching the child through the schools is perhaps more important as a permanent and effective program. The responsibility of adequately instructing the child in matters of personal health and individual responsibility to reduce the hazards of preventable diseases is not incumbent upon any one professional or educational group. Desired results unquestionably can be accomplished with greater facility through a community of interest on the part of all interested participants. The Joint Committee can, and does, serve as a neutral body through which major interest groups work without losing the identity of the participating unit. It is this factor of active coöperation to the end that better and more effective means of instructing the children of Michigan on matters of health, that the Joint Committee serves its most useful function. Thus, during the past two years, through a

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sub-committee on School Health Education, instructional aids in the form of bulletins have been printed and distributed to school teachers. An active program to arouse school administrators and teacher interest in health education and more adequate instruction in healthful living for persons who are training to become teachers has been inaugurated.

The reports and discussions at the annual meeting in Ann Arbor were noteworthy in revealing the unselfish activities of persons affiliated with different groups who have given freely of their time and services with no thought of compensation but rather the development of a sound program seeking to familiarize both adults and children with the available information on the prevention of communicable diseases and in matters of personal hygiene.

At the close of the meeting, Burton R. Corbus, M.D., chairman of the State Medical Society's Representatives to the Joint Committee on Health Education, was unanimously elected as chairman for the ensuing year.

\* \* \*

The Alumni Association of the Wayne University College of Medicine held its forty-ninth Annual Reunion and the Detroit Clinics, Wednesday, June 15 and 16, 1938. This year the program was arranged by Dr. Frederick J. Buesser, president, and Drs. Fred H. Cole, W. W. MacGregor, George C. Burr, Wadsworth Warren, C. E. Umphrey and Volney Butler of the Alumni Association and Dean Raymond Allen and Professor Gordon Myers of the College of Medicine.

Wednesday, June 15, was devoted to a scientific program at the College Auditorium on Mullett Street, Detroit, beginning at 9 A. M.

- 9:00 A. M.—The Clinical Application of Sulfanilamide.  
General Introduction—Gordon B. Myers, M.D., F.A.C.P., Professor of Medicine.  
9:30—Its Application in Gonorrhea—George Sewell, M.D., F.A.C.S., Department of Urology.  
9:40—Its Application in Pneumonia—Alvin E. Price, M.D., F.A.C.P., Department of Medicine.  
9:50—Its Application in Puerperal Infections—A. E. Catherwood, M.D., F.A.C.S.  
10:00 A. M.—Physiology of the Sex Hormones—Warren O. Nelson, B.S., M.S., Ph.D., Professor of Anatomy.  
10:30—Clinical Use of the Sex Hormones—Robert C. Moehlig, M.D., F.A.C.P., Department of Medicine.  
11:00 A. M.—The Biochemistry of Vitamin B Complex—Arthur H. Smith, B.S., M.S., Ph.D., Professor of Physiological Chemistry.  
11:30—The Relationship of Vitamin B to Cardiology—Douglas Donald, M.D., F.A.C.P., Department of Medicine.  
11:40—The Relationship of Vitamin B to Gastroenterology—Harold J. Kullman, M.D., F.A.C.P., Department of Medicine.  
11:50—The Relationship of Vitamin B to Neurology—Edward D. Spalding, M.D., F.A.C.P., Department of Medicine.  
12:00 Noon—The Annual Meeting of the Alumni Association of Wayne University College of Medicine.  
1:00 P. M.—Complimentary Luncheon at the College.  
*At Receiving Hospital*  
2:00 P. M.—Demonstration of the Cooksey (Baxter) Method of Blood Transfusion—Warren G. Cooksey, M.D., F.A.C.P., Department of Medicine.  
2:20—Demonstration of Gastrointestinal suction by use of the long tube in Intestinal Obstruction—James M. Winfield, M.D., F.A.C.S., Department of Surgery.  
2:40—Demonstration of the Technique of Artificial Pneumothorax—E. J. O'Brien, M.D., F.A.C.S., Department of Surgery.  
3:00 P. M.—Demonstration of the Treatment of Varicose Veins—E. A. Osius, M.D., F.A.C.S.; E. H. Lauppe, M.D., F.A.C.S., and C. N. Weller, M.D., F.A.C.S.

Thursday, June 16, was given over to the Commencement Program of Wayne University beginning at 10 A. M.

- 1:30 P. M.—Visit to Parke, Davis and Company Plant.  
2:30 P. M.—The Boat Ride—Steamer Put-In-Bay.  
7:00 P. M.—Class Reunions—Classes of 1883, 1888, 1893, 1898, 1903, 1908, 1913, 1918, 1923, 1928, 1933.

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*The Michigan Attorney General*, in an opinion dated March 25, 1938, further amplifies the status of chiropractors in Michigan as follows:

"Does the circulation of a pamphlet by a chiropractor who holds himself out to diagnose and treat disease constitute a violation of the Medical Practice Act?"

It is provided by Section 6 of Act No. 145 of the Public Acts of 1933 as follows:

"The license provided for in this act shall entitle the holder thereof to practice chiropractic in the state of Michigan, and for the purpose of this act chiropractic is defined as 'the locating of misaligned or displaced vertebrae of the human spine, the procedure preparatory to and the adjustment by hand of such misaligned or displaced vertebrae and surrounding bones or tissues.'"

The license provided for and by said Act does not confer upon the holder the right to treat diseases by any method he may choose; he is limited to the treatment of ailments by means of spinal adjustments.

To the extent that a chiropractor treats disease by other methods than those he is entitled by law to use, he is engaged in the illegal practice of medicine. In *re Rust*, 181 Cal. 73; 183 Pac. 548; *State Board of Medical Examiners vs. O'Neil* (N.J.) 143 Atl. 814.

Actual treatment is not necessary to constitute a violation of the medical practice act. It is a violation thereof for an unlicensed individual to hold himself out to the public or profess to be able to diagnose, treat, cure, or relieve human diseases and ailments. *State vs. Heath*, 125 Ia. 585; 101 N.W. 429.

Should the equipment to which reference is made in the pamphlet be a device for the treatment of ailments or disorders by other means than manipulation or adjustment of the human spine, which fact does not clearly appear from the description in the pamphlet, this would constitute a violation of the Medical Practice Act.

As you undoubtedly know, the exact line of demarcation between the practice of medicine and the other healing professions is often difficult to determine in view of the absence of judicial precedents; much depends upon the facts of each particular case.

\* \* \*

*Medical Care* (extract from talk by Surgeon General Thomas Parran of the State and Territorial Health Officers' Conference held in Washington, D. C., April, 1938):

"Among public health administrators there may have been in the past some difference of opinion as to status of medical care in the public health program. In well informed circles there is no longer much room for argument on this question. Whether we like it or not, the public health forces are faced with a challenge that will not be denied. A large proportion of our national population are without the means of securing adequate medical care when sickness strikes. The traditional measures for meeting the need of medical care among indigent and low income groups have almost universally demonstrated their pitiful inadequacy. The demand, which a year ago was a fitful breeze, has grown to hurricane proportions. A comprehensive program for medical care is an impending national issue, with which the health agencies can no longer temporize. The time has come for frank and unimpassioned discussion of this problem between public health and medical practice groups, and for the formulation of a constructive program mutually helpful and advantageous to all. Medical practice groups should be assured that they have nothing to fear but rather much to gain from participation of public health agencies in the administrative direction of public medical care activities.

"The Interdepartmental Committee, of which Miss Josephine Roche is chairman, has been studying

the problem of public health needs, including medical care, and has prepared a preliminary report. It is the purpose of this Committee to call a conference this summer to which will be invited representative leaders in public health medical practice, and other groups interested. From this conference should issue a united front to fill the need for medical care in the under-privileged groups of our social order."

\* \* \*

#### Dr. Charles H. Baker Honored

Dr. Charles Harper Baker of Bay City was honored at a testimonial dinner on May 5. The program took the form of a mock trial with a happy verdict. Dr. Baker was presented with a plaque signifying his position as dean of the medical profession of the Bay County Medical Society. The presentation was made by Dr. W. R. Ballard. Dr. Baker responded by an address on the progress of medicine since his graduation in 1883, from the time when a young doctor could not even afford the price of a horse and buggy.

There were sixty-five guests and friends present. Among those from out of town were Dr. William Clift of Flint, Dr. Louis J. Hirschman of Detroit, past president of the Michigan State Medical Society, Dr. R. H. Baker of Pontiac, son of the honored guest, Mr. and Mrs. James E. Davidson of Bay City, Dr. William Haughey and Dr. Wilfred Haughey of Battle Creek, Dr. Henry Cook of Flint, president of the Michigan State Medical Society, and Mr. Wm. J. Burns of Lansing, executive secretary of the Michigan State Medical Society. Dr. Baker himself is a past president of the Michigan State Medical Society. The editor of this JOURNAL joins in extending congratulations to Dr. Baker in his honorable career as physician and citizen. Dr. C. L. Hess presided at the banquet.

\* \* \*

#### Ingham County State Night

The closing meeting of the Ingham County Medical Society for the spring term was held at Lansing on May 17. This was a combination of a scientific meeting and a meeting with a number of officials, councillors and chairman of the House of Delegates of the Michigan State Medical Society. Following the dinner, the program of the evening consisted of a discussion of the subject of syphilis. The Ingham County Medical Society began over two and a half years ago to investigate independently the subject of syphilis in Ingham County, the investigation being carried on with the aid of the United States Public Health Service, and also the Michigan Department of Health. The program consisted for the most part of a paper by Dr. Asemyer embodying the results of two and a half years survey. Papers were also presented by Dr. H. L. Keim and Dr. R. S. Breakey. Since we look forward in the near future to presenting the results of this survey, nothing further need be said at this time.

Dr. Stuckey, who has been for a number of years in charge of the Tuberculosis Sanitarium, goes to the Kellogg Foundation. Dr. Shaw, in presenting a resolution and Dr. Christian as a seconder, paid Dr. Stuckey a glowing tribute as what they called a private practitioner engaged in preventive medicine. Dr. Henry Cook, president of the society, and Dr. Loren Schafer, chairman of the state committee on syphilis control, were introduced. Dr. Don M. Gudakunst, commissioner of health, also spoke briefly, as well as Dr. George Belote, Assistant Professor of Dermatology at the University of Michigan.

Ingham County has led the way in the matter of syphilis survey. The findings of the committee on syphilis will be read with interest by the members from every county in the state.



## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**HANDBOOK ON NASAL ACCESSORY SINUSES:** By Frank L. Assoway, B.Sc., M.D., Formerly Chief, Dept. of Otolaryngology, U. S. Diagnostic Clinic, Washington, D. C., Fellow A.M.A., Academy of Otolaryngology and Ophthalmology, American Board of Otolaryngology, Lt. Col. M.C., U.S.A. (R), Flight Surgeon, U.S.A. (R); Otolaryngologist at Holston Valley Com. Hospital. Kingsport, Tennessee: Kingsport Press, Inc., 1937.

The author has gathered into one small volume of 120 pages what he calls some of the basic principles of nasal accessory sinusitis. Sinusitis, particularly in Michigan, has become so universal that every layman has his own ideas on the subject. This little book, however, is not for laymen. It contains in small compass as already mentioned, the essential facts with directions for treatment.

**RECENT ADVANCES IN PATHOLOGY.** By Geoffrey Hadfield, M.D., F.R.C.P. (Lond.), Professor of Pathology in the University of London, Pathologist to St. Bartholomew's Hospital, formerly Examiner in Pathology in the University of London and Lawrence P. Garrod, M.D., B.Ch. (Camb.), F.R.C.P. (Lond.), Professor of Bacteriology in the University of London, Bacteriologist to St. Bartholomew's Hospital, Examiner in Pathology in the University of Cambridge. Third Edition, 65 illustrations. Philadelphia: P. Blakiston's Son & Co., Inc., 1938.

This volume is devoted to a broad discussion of a number of diseases in which the newer knowledge is presented. Of general interest are the chapters on the deficiency diseases, diseases of the heart and arteries, pneumonia, the pneumoconioses, diseases of the liver and digestive system, Bright's disease, the central nervous system, and the ductless glands. The subjects are presented in a clear, concise, and easily understandable manner with the emphasis on their practical aspects. As is so often true of English writers, the style is free and smooth and one finds himself reading on and on without apparent effort as new ideas are successively presented. The volume is highly informative and stimulating, and is easily read.

**THE PRACTICE OF UROLOGY.** By Leon Herman, B.S., M.D., Professor of Urology, University of Pennsylvania, Graduate School of Medicine; Urologist to the Pennsylvania Hospital and to the Bryn Mawr Hospital; Consulting Urologist to the Methodist Episcopal and Burlington County (New Jersey) Hospitals. 923 pages with 504 illustrations. Philadelphia and London: W. B. Saunders Company, 1938. Cloth, \$10.00 net.

The subject of diagnosis and treatment of diseases of the genito-urinary tract is adequately presented in this volume. Technic in cystoscopy is given in detail as well as the significance of the cystoscopic findings. Urography by both the intravenous and the retrograde methods is fully described. The work is well illustrated and easy to comprehend. The author has written a work that will be found acceptable to the class for whom it is intended, the general practitioner and the surgeon.

**TREATMENT IN GENERAL PRACTICE.** By Harry Beckman, M.D., Professor of Pharmacology at Marquette University School of Medicine, Milwaukee, Wisconsin. Third edition, revised and entirely reset. Philadelphia and London: W. B. Saunders Company, 1938.

In this third edition of "Treatment in General Practice" the author has attempted to offer a work that will fill the need for a thorough knowledge of the methods of treatment of all diseases that do not "by prescriptive right belong to the domain of the legitimate specialties." There has been some slight reorganization of the plan of the work in this edition, yet nothing that should rightfully come within the scope of a work of this sort has been omitted.

Several new sections have been added and many new disease entities have been given consideration in this edition for the first time.

While this is intended to be a work covering, only, the subject of treatment, at the beginning of each subject the author gives a brief summary of the present knowledge of the disease. In discussing the treatment of a given disease, the author has included all the methods now in vogue and has tried to show the value of each in the light of present knowledge. In his handling of the subject he has included the later methods which depend upon chemotherapy and has discussed methods that are regarded by some as controversial.

**TEXTBOOK OF CLINICAL PATHOLOGY,** edited by Roy R. Kracke, B.S., M.D., Professor of Pathology, Bacteriology and Laboratory Diagnosis, Chairman of the Department, Emory University, Pathologist to the University Hospital. Contributors are Alfred P. Briggs, B.S., M.D., Associate Professor of Biochemistry and Medicine, University of Georgia School of Medicine; L. W. Diggs, M.A., M.D., Assistant Professor of Medicine, University of Tennessee, College of Medicine; George Herrmann, M.S., M.D., Ph.D., Professor of Clinical Medicine, University of Texas School of Medicine; Foster M. Johns, M.D., Assistant Professor of Clinical Medicine, Tulane University School of Medicine; Francis B. Johnson, M.D., Professor of Clinical Pathology, Medical College of South Carolina; Roy R. Kracke, B.S., M.D.; Ralph McBurney, M.D., Professor of Bacteriology and Hygiene, University of Alabama School of Medicine; Henry E. Meleney, M.D., Asso. Professor Preventive Medicine, Vanderbilt University School of Medicine; A. J. Miller, M.D., Professor Pathology and Serology, University of Louisville School of Medicine; Francis P. Parker, M.D., Assistant Professor of Pathology, Bacteriology, Emory University School of Medicine; V. P. Sydenstricker, M.D., Professor of Medicine, University of Georgia School of Medicine, and Joel G. Wahlin, Ph.D., Professor of Bacteriology, University of Arkansas School of Medicine. Baltimore: William Wood & Company Division, The Williams & Wilkins Company. 1938. Price \$6.00.

This work on Clinical Pathology describes in detail the usual clinical laboratory examinations, but its value lies in the fact that it does a great deal more. It interprets the results of such tests and their application to diagnosis. One outstanding merit of the work is its composite authorship, each contributor an outstanding clinician in a particular field. All are teachers; therefore the volume as one has a right to expect, is one of pedagogical merit. The illustrations are well chosen so that we have a clear and interesting presentation of the subject of clinical pathology, both technic and interpretation.

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## Among Our Contributors

Dr. Alvan L. Barach was graduated from the College of Physicians and Surgeons, Columbia University, in 1919, and began research work at the Massachusetts General Hospital as assistant in medicine, Harvard Medical School. He is now Assistant Professor of Clinical Medicine at the Columbia College of Physicians and Surgeons, and assistant attending physician at the Presbyterian Hospital, New York City.

\* \* \*

Dr. R. L. Dixon is a graduate of the University of Michigan Medical School, 1910. He was instructor in Pathology 1908-09, 1910-11; Executive Officer State Health Department, 1911-1913; Medical Superintendent State Hospital for Epileptics, 1914-1930; Medical Superintendent Michigan Home and Training School, 1930-1937. Dr. Dixon recently returned to the superintendency of the State Hospital for Epileptics. He is a Fellow of the American Psychiatric Association and a member of the American Association on Mental Deficiency, and International League Against Epilepsy. His specialty is epilepsy and other convulsive disorders.

\* \* \*

Dr. E. A. Hand was graduated from the University of Michigan, M.D., in 1932, M.S. in Dermatology and Syphilology, 1936. He has been in private practice at Saginaw since 1936, specializing in Dermatology and Syphilology.

\* \* \*

Dr. Hermann Pinkus was graduated from the University of Berlin, Germany, in 1929, and has had postgraduate training in dermatology with Dr. J. Jadassohn at the University of Breslau, Germany. Dr. Pinkus was a research fellow in tissue culture in the Department of Surgery, University of Michigan, from 1934 to 1936. Since July 1, 1936, he has been connected with Eloise Hospital as a research fellow in the Departments of Dermatology and Pathology.

\* \* \*

Dr. George W. Slagle was graduated from the University of Michigan in 1933. He was associated with the late Dr. Elmer L. Eggleston at the Battle Creek Sanitarium for three years, and now is in private practice limited to internal medicine.

\* \* \*

Dr. John George Slevin obtained his Bachelor of Science degree from the University of Detroit in 1925. He was graduated from St. Louis University with an M.D. degree in 1929, and interned at Grace Hospital, Detroit, 1929-1930. Dr. Slevin was surgical assistant to Dr. H. W. Hewitt of Detroit from 1930 to 1936, and he is at the present assistant attending surgeon at Grace Hospital, Detroit.

\* \* \*

Dr. James A. Spencer was graduated from the University of Michigan Medical School in 1931. Following an internship at Hurley Hospital, Flint, he spent two years as assistant and medical director on the staff of Fisher Body Corporation. He has been in private practice in Flint since 1935 and is now on the consulting staff of traumatic surgery at Hurley Hospital.

(Continued on Page 575)

## THE Forty-ninth Annual Reunion AND THE Detroit Clinic

of the Alumni Association of the  
Wayne University College of Medicine

Wednesday, June 15, 1938

at the

### COLLEGE AUDITORIUM

629 Mullet Street, Detroit, Michigan

- 9:00 A.M. The clinical application of sulfanilamide. General introduction—Gordon B. Myers, M.D., F.A.C.P., Professor of Medicine
- 9:30 A.M. Its application in Gonorrhea—George Sewell, M.D., F.A.C.S., Dep't of Urology
- 9:40 A.M. Its application in Pneumonia—Alvin E. Price, M.D., F.A.C.P., Dep't of Medicine
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- 11:50 A.M. The Relationship of Vitamin B to Neurology—Edward D. Spalding, M.D., F.A.C.P., Dep't of Medicine
- 12:00 Noon The Annual Meeting of the Alumni Association of Wayne University College of Medicine
- 1:00 P.M. Complimentary Luncheon at the College.

### AT RECEIVING HOSPITAL

- 2:00 P.M. Demonstration of the Cooksey (Baxter) Method of Blood Transfusion—Warren G. Cooksey, M.D., F.A.C.P., Dep't of Medicine
- 2:20 P.M. Demonstration of Gastrointestinal Suction by use of the long tube in Intestinal Obstruction—James M. Winfield, M.D., F.A.C.S., Dep't of Surgery
- 2:40 P.M. Demonstration of the Technique of Artificial Pneumothorax—E. J. O'Brien, M.D., F.A.C.S., Dep't of Surgery
- 3:00 P.M. Demonstration of the Treatment of Varicose Veins—E. A. Osius, M.D., F.A.C.S.; E. H. Lauppe, M.D., F.A.C.S.; and C. N. Weller, M.D., F.A.C.S.
- 7:00 P.M. Student-Faculty-Alumni dinner. Hotel Fort Shelby

### THURSDAY, JUNE 16, 1938

- 10:00 A.M. Commencement Programme
- 1:30 P.M. Visit to Parke, Davis and Company Plant
- 2:30 P.M. The Boat Ride—Steamer Put-In-Bay
- 7:00 P.M. Class Reunions—Classes of 1883, 1888, 1893, 1898, 1903, 1908, 1913, 1918, 1923, 1928, 1933.



# COUNTY SOCIETIES

## BRANCHES OF THE MICHIGAN STATE MEDICAL SOCIETY

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING	
			Regular	Annual
Allegan .....	E. T. BRUNSON Ganges	M. B. BECKETT Allegan	1st Tuesday	1st Tuesday December
Alpena-Alcona- Presque Isle.....	W. E. NESBITT Alpena	HAROLD KESSLER Alpena	Last Thursday 6:00 p. m.	Last Thursday December
Barry .....	G. F. FISHER Hastings	THOMAS H. COBB Woodland	2nd Thursday 8:00 p. m.	1st Thursday January
Bay-Arenac-Iosco- Gladwin .....	C. L. HESS Bay City	A. L. ZILIAK Bay City	2nd and 4th Wednesday (ex- cept July, Aug., Sept.) 6:00 p. m.	2nd Wednesday December
Berrien .....	HARRY KOK Benton Harbor	A. F. BLIESMER St. Joseph	2nd Wednesday or Thursday	2nd Wednesday or Thursday, December
Branch .....	N. S. ALDRICH Coldwater	F. S. LEEDER Coldwater	3rd Thursday 6:30 p. m.	3rd Thursday December
Calhoun .....	J. E. ROSENFELD Battle Creek	WILFRID HAUGHEY Battle Creek	1st Tuesday (except July and Aug.)	1st Tuesday December
Cass .....	K. C. PIERCE Dowagiac	GEO. LOUPEE Dowagiac	2nd Wednesday or Thursday	December 15
Chippewa- Mackinac .....	J. F. DARBY St. Ignace	DWIGHT F. SCOTT Sault Ste. Marie	1st Thursday 7:30 p. m.	1st Thursday December
Clinton .....	F. E. LUTON St. Johns	T. Y. HO St. Johns	Last Tuesday (Oct. to June, incl.)	Last Tuesday October
Delta .....	W. A. LEMIRE Escanaba	G. W. BENSON Escanaba	1st Thursday 8:30 p. m.	December 2
Dickinson-Iron .....	L. E. IRVINE Iron River	W. H. HURON Iron Mountain	1st Thursday 6:30 p. m.	1st Thursday December
Eaton .....	H. A. MOYER Charlotte	THOMAS WILENSKY Eaton Rapids	3rd Thursday	No set date
Genesee .....	A. MCARTHUR Flint	C. W. COLWELL Flint	2nd and 4th Tuesday (ex- cept July and August)	2nd Tuesday November
Gogebic .....	CHAS. E. ANDERSON Bessemer	WM. H. WACEK Ironwood	3rd Tuesday	3rd Tuesday December
Grand Traverse- Leelanau-Benzie	MARK OSTERLIN Traverse City	C. E. LEMEN Traverse City	1st Tuesday 8:00 p. m.	1st Tuesday December
Gratiot-Isabella- Clare .....	C. M. BASKERVILLE Mt. Pleasant	RICHARD L. WAGGONER St. Louis	3rd Thursday	3rd Thursday December
Hillsdale .....	W. E. ALLEGER Pittsford	E. G. MCGAVRAN Hillsdale	Last Thursday	Last Thursday December
Houghton-Baraga- Keweenaw .....	R. S. BUCKLAND Baraga	C. A. COOPER Hancock	1st Tuesday	1st Tuesday January
Huron-Sanilac .....	R. R. GETTEL Kinde	E. W. BLANCHARD Deckerville	2nd Thursday	2nd Thursday December
Ingham .....	DANA M. SNELL Lansing	R. J. HIMMELBERGER Lansing	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Ionia-Montcalm ....	R. R. WHITTEN Ionia	JOHN J. McCANN Ionia	2nd Tuesday 7:00 p. m.	2nd Tuesday December
Jackson .....	JOHN VAN SCHOICK Hanover	H. W. PORTER Jackson	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kalamazoo- Van Buren .....	R. J. HUBBELL Kalamazoo	L. W. GERSTNER Kalamazoo	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kent .....	A. J. BAKER Grand Rapids	J. M. WHALEN Grand Rapids	2nd and 4th Wednesday 8:15 p. m.	2nd Wednesday December
Lapeer .....	G. C. BISHOP Almont	C. C. JACKSON Imlay City	2nd Thursday	December or January
Lenawee .....	CHAD A. VAN DUSEN Blissfield	ESLI T. MORDEN Adrian	3rd Tuesday	3rd Tuesday October
Livingston .....	BERNARD H. GLENN Fowlerville	DUNCAN C. STEPHENS Howell	1st Friday 6:30 p. m.	1st Friday December
Luce .....	A. T. REHN Newberry	C. D. HART Newberry	1st Tuesday 8:00 p. m.	1st Tuesday December
Macomb .....	JOSEPH N. SCHER Mt. Clemens	R. F. SALOT Mt. Clemens	1st Monday 12:00 noon	1st Monday December
Manistee .....	KATHRYN BRYAN Manistee	C. L. GRANT Manistee	Every Monday noon	1st Monday December
Marquette-Alger ....	N. J. McCANN Ishpeming	D. P. HORNBOKEN Marquette	No set date	December
Mason .....	V. J. BLANCHETTE Custer	CHAS A. PAUKSTIS Ludington	2nd Tuesday	2nd Tuesday December
Mecosta-Osceola ...	L. F. CHESS Reed City	GLENN GRIEVE Big Rapids	2nd Tuesday	2nd Tuesday December

## COUNTY SOCIETIES

Menominee .....	JOHN TOWEY Powers	WM. S. JONES Menominee	3rd Thursday	3rd Thursday December
Midland .....	CHAS. L. MacCALLUM Midland	N. C. GREWE Midland	2nd Thursday	2nd Thursday December
Monroe .....	W. J. GELHAUS Monroe	FLORENCE AMES Monroe	3rd Thursday (except July and Aug.)	3rd Thursday October
Muskegon .....	CHAS. A. TEIFER Muskegon	L. E. HOLLY Muskegon	Last Friday 6:00 p. m.	2nd Friday December
Newaygo .....	LAMBERT GEERLINGS Fremont	W. H. BARNUM Fremont	As called	3rd Tuesday December
Northern Mich. (Antrim- Charlevoix- Emmet- Cheboygan) .....	B. H. VANLEUVEN Petoskey	W. E. LARSON Levering	2nd Thursday 6:00 p. m.	2nd Thursday December
Oakland .....	AARON RIKER Pontiac	O. O. BECK Birmingham	1st Wednesday (except July and Aug.)	1st Wednesday December
Oceana .....	MERLE G. WOOD Hart	N. W. HEYSETT Hart	No definite date set	December
O.M.C.O.R.O. (Otsego- Montmorency- Crawford-Oscoda- Roscommon- Ogemaw) .....	LEVI A. HARRIS Gaylord	C. G. CLIPPERT Grayling	On call	December
Ontonagon .....	F. W. McHUGH Ontonagon	E. J. EVANS Ontonagon	On call	January
Ottawa .....	GERRIT KEMME Zeeland	D. C. BLOEMENDAL Zeeland	2nd Tuesday Noon	2nd Tuesday December
Saginaw .....	W. K. ANDERSON Saginaw	H. C. WALLACE Saginaw	3rd Tuesday 8:30 p. m.	3rd Tuesday December
Schoolcraft .....	A. R. TUCKER Manistique	GEO. A. SHAW Manistique	On call	January 10
Shiawassee .....	W. E. WARD Owosso	R. J. BROWN Owosso	3rd Thursday Noon	3rd Thursday December
St. Clair .....	C. A. MacPHERSON St. Clair	JACOB H. BURLEY Port Huron	1st and 3rd Tuesdays Oct. to June	3rd Tuesday December
St. Joseph .....	R. A. SPRINGER Centreville	JOHN W. RICE Sturgis	1st Thursday 6:30 p. m.	1st Thursday January
Tuscola .....	LLOYD L. SAVAGE Caro	R. R. HOWLETT Caro	2nd Thursday 8:00 p. m.	2nd Thursday November
Washtenaw .....	S. L. LAFEVER Ann Arbor	WM. M. BRACE Ann Arbor	2nd Tuesday	2nd Tuesday December
Wayne .....	HENRY R. CARSTENS Detroit	B. I. JOHNSTONE Detroit	Every Monday 8:45 p. m. (Oct. to May, incl.)	3rd Monday in May
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### AMONG OUR CONTRIBUTORS

(Continued from Page 573)

**Dr. Franklin H. Top** was graduated from Calvin College in 1925 and received his M.D. degree from the University of Pennsylvania in 1928, and C.P.H. from Johns Hopkins University in 1935. Dr. Top is Director of Communicable Diseases and Epidemiology, Detroit Department of Health and Herman Kiefer Hospital, Clinical Instructor, Department of Preventive Medicine and Public Health, Wayne University, and Special Lecturer in infectious diseases and epidemiology at the University of Michigan.

\* \* \*

**Dr. D. C. Young** is a graduate of the Detroit College of Medicine, 1925. He is Chief Physician, Communicable Disease Service of Herman Kiefer Hospital, and Clinical Lecturer in infectious diseases at Wayne University.



**Hours:**  
9 - 5:30

# HACK'S FOOT NOTES

**RAndolph**  
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Vol. VIII

Detroit, Michigan, June, 1938

No. 6

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# THE JOURNAL

OF THE

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No. 7

## THE DOCTOR AND A SCHOOL HEALTH PROGRAM\*

HENRY COOK, M.D.

FLINT, MICHIGAN

When one gives thought and consideration to the problems of health he must necessarily take into consideration the fact that a health problem of a community is one of the many problems that exist in that community. There is first, the need of supplying the very essential needs such as food, clothing and shelter. Next comes the problem of health and education. It is generally considered that education comes ahead of health since education is a means both to existence and to health. The need of first essentials of existence is always recognized. Education is very popular with the parents and with the large percentage of our population. The health needs of our people are approached in a different manner by different groups of our population. All of us want health, but many of us do not know how to obtain it, and if we know how to obtain it are not willing to make the effort or pay the price to obtain it. Some probably are not able to pay the price, and others do not know how to or where to obtain it.

There never was a time when there was so great a general interest in the health of our people as now. There have been various foundations and philanthropists, also various voluntary health agencies, that have from time to time interested themselves in the problems of health. At present, various magazine writers are contributing articles upon health and means of providing it. All too frequently, these individuals are not willing to approach the problem fairly and honestly, giving all sides to the question, but seem to feel that they must further propaganda either to satisfy their own ego or to furnish something to magazines catchy

enough to interest the reader. Fortunately, there seems to be a tendency more and more, to realize and furnish the facts. Many of these voluntary agencies also had preconceived ideas as to the manner of approach to the problem and its solution. Their motive was good; some good results were obtained, but the benefits have not always justified the effort. There is no question that they have increased the interest, which was a wholesome result. The need of greater attention to health has been generally recognized by the medical profession, contrary to the opinion of many. These needs have often been called to the attention of the public by the medical profession. It is my opinion that a great deal of the effort which might have been put forth by the medical profession in coöperation with these agencies was not exerted because of recognition by the medical profession of the futility of such procedures, and because of the fact that these organizations were not open-minded enough to work out a coöperative plan. In support of the contention that this procedure is necessary, I wish to call to your attention the work of the Kellogg Foundation, the Detroit Board of Health and the

\*Presented by Dr. Cook, President of the Michigan State Medical Society, before a School Health Educational group May 27, 1938.



Childrens' Fund of Michigan. These foundations have to a more or less degree formulated their plans in conjunction with organized medicine, either state or local.

I would like to make the point at this time that one of the greatest barriers to the support by the medical profession of many health programs is the lack of understanding of the medical ethics. It must be recognized that the principle of not interfering between the patient and his physician must be held inviolate if the best results are to be obtained and if coöperation of the medical profession is to be given. The medical profession has always been willing to give its aid and its advice in medical problems which have to do with health, whenever it has been honestly sought and this principle recognized. I believe, in fact I am certain, that most of the larger organizations successfully dealing with health today, recognize this ethical need and are strictly adhering to it.

There is no question that our health organizations, including state and local, have contributed greatly to the health of our communities, and when I speak of local agencies I wish especially to call attention to the school health programs of the various communities. I believe that it goes without saying that all of our agencies outside of the medical profession, which are really active in the work, recognize the need of a better correlation of the activities of all individuals and organizations which have to do with the problem of health. This is especially true in the health work in our schools because school health work is a major part of, but still a part of the general health program of a community, and while this is true it needs special attention under the guidance of some one especially trained in school health work.

Let us consider the various individuals who have to do with the establishment of and effectively carrying on a good school health program. We have first, your school administrative staff, your school board to whom the administrative force is responsible and who must see that funds are supplied to carry on the work. You have also the principals of the various schools, the class room teachers and your physical education teachers. Then you have the parents whose coöperation is so essential, as well as the doctor who must coöperate with the schools in the work outside of the school. If the funds are to be provided, your Board of Education

and your administrative staff must be sympathetic to this health work. Your administrative staff and your school physician, who is so important, and his staff of nurses, your teaching staff, your physicians who are members of the school staff, must recognize the essential things in the work of the program and must, at all times, recognize what their own part is in the program, as well as the rights and duties of the other individuals or groups, and must, at all times, respect and recognize the position of each other. If they do not respect the relationships of each other, confidence is destroyed, and coöperation is entirely dependent upon confidence.

Let me quote Surgeon-General Thomas J. Parran: "Most of the complications which have disturbed the relationship between public health workers and private practitioners of medicine are unnecessary. In some cases highly competent physicians have failed to take the requisite interest in proven public health methods. On the other hand, many able public health administrators have lost touch with the clinical viewpoint and personal problems of the private practitioner. Lack of understanding is bound to breed clashes between two groups who are necessarily in close contact in their daily work. Knowledge and freedom from prejudice are indispensable to the solution of scientific problems. They are no less necessary to the establishment of a harmonious relationship between public health work and private medical practice, which are the two useful arms of the greatest of sciences."

Let me also quote our State Health Commissioner, Dr. Don W. Gudakunst: "A careful analysis of the situation reveals that the school health programs have been very ineffectual." He points out the need of the physician being made an integral part of the school health program. He also states that coöperation and assistance from any group of individuals, be they physicians or others, need not be expected unless they are fully aware of the procedures and play some part in every step. He states further: "Most of the efforts have been directed to sending children to physicians without adequate thought to the preparation of the physician to meet the special problem. The physician then needs special training in this work."

I believe that a careful analysis will show that in our school health work over the past

two decades we have set out upon a campaign of finding defects and their correction, also carrying on a campaign of immunization and disease prevention, certain education as to diet and care of the body, and finding that each year following we had the same number of defects to correct and the same problems existed as did the previous year.

We have, through this system of correction of defects in the school, taught the child and the parent not to correct a defect himself but to look to the school for this service, when, after all, a school is an educational institution. It is far more important to teach an individual to look after himself than it is to teach him to be a dependent. We must also recognize that our dependency is increasing to such an extent that the time will come when we will not be able to meet the problems if we have not already come to that time.

Keeping in mind the points which I have tried to make previously, and having the funds available in the development of school health programs, we take into consideration those who have part in the work. We have first, a school physician who has entered the field of school health work for various reasons. First, he may be a young man who has just served his internship, but for economic reasons he may feel that a job with a salary gives him more assurance of security. He may be an older man who has not done well in private practice, or he may be a man of good training with proper experience in the work. His attitude may be that education in health is of prime importance, or he may feel that it is the job of his department to correct defects. The attitude of the school physician will be reflected in the whole program, in the work of his whole staff and in the work of all people in the schools who have a part in the program. If his prime interest is in health education, education will be the prime motive, or if he has not the viewpoint of the need of health education the program of all in the schools will be towards the correction of defects and health education will take a minor rôle. On the other hand, in my opinion, if he is interested in health education and in teaching the child and the parent what needs to be done and how to obtain it through health education, many of these people will take care of themselves, saving

the school funds for a broader program of health education.

I do not wish it to be understood that I feel any child who needs medical care and is unable to obtain it, should not be cared for. I shall later, point out the way in which that should be handled.

This school physician will have, at his hand, a group of nurses employed to do school health work with various trainings and backing of experience. Some will have one viewpoint and some will have another. Some will understand the motives of the program and plans, some will be sympathetic to it; all of these nurses must be molded into an organization willing to give their best efforts because they believe in the program. On the other hand, you have a group of school teachers, class room and physical education teachers. The class room teacher has had very little training in health work. She will be sympathetic to any reasonable program and will usually follow the leadership of the school physician and the school nurse if the teacher thinks it is a worthwhile program. It must be sold to them. The teacher is the one who probably has the least formed opinion. Then, we consider the group of physical education teachers who have received certain information as regards health from various sources and colleges, no two of whom have the same ideas, each teacher having to a degree an opinion of his own. They are sympathetic to health work, in fact, they are much more enthusiastic than the ordinary class room teacher since they have had more interest in health work. However, the opinion of all these people must be molded into the program.

Then, on the other hand, you have the private doctors, many of whom are practicing individualistic medicine, who have not learned to think in terms of group practice and are not experienced in collective thinking, who sometimes have had unfortunate experiences with certain public health officials who did not recognize the problem of the private physician and who probably feel that the private doctor is critical of them. Fortunately, this is not always true. There are many physicians who are studying and thinking today in terms of the health interests and health welfare of the community and are willing to lend support to any group or groups of individuals who are hon-



est in their efforts to solve these problems. They, however, will not have confidence, let me repeat, in any group of health officials who do not recognize the relationship of a doctor to his patient. It is not financial, but it is relationship which a doctor prizes highly and wishes no one to interfere with it. Possibly, many may feel that this is an unreasonable position—the doctor does not think so.

I have endeavored to point out to you the idiosyncracies of these various groups which we have to deal with, but it is necessary that we recognize these idiosyncrasies in the working out of a health program, and if any health program is to be worked out and it is to receive the coöperation of any one of these groups, it must be worked out by them through joint effort and coöperation. This has its advantages, first, because each one will then understand what the program is and what they are trying to accomplish. It is his baby and every father loves his own child. Then, and only then, can you expect the support of each group. All the differences of opinion must have been ironed out in advance in so far as possible. There will be enough which will arise afterwards.

It is probable that in the working out of a program it is better to have the medical profession represented by a committee especially interested in and sympathetic to the school health program. After this program is worked out and approved by all, then it will be the job of the committee of which the school physician is a member, to explain and sell it to the medical profession in that community. If this is done properly, a certain per centage of the physicians in that community will be perfectly willing and anxious to coöperate. However, we must keep in mind the background of what has transpired in the relationships between the medical profession, the dental profession and our school organization in the past. There may be certain prejudices and certain misunderstandings that still need to be wiped out. Then again there may have been a good understanding and good working arrangements before, and it would then be easier to effect the program.

This advisory committee to the school physician has two advantages and should be continuous. In the first place, it is the approach to the medical profession of the community and should be able to iron out

many of the difficulties before they occur. Secondly, it should be a very helpful medium in getting across to the medical profession of the community what the problem really is and what the schools are trying to do to educate the parent and the child in health. They would also become familiar with the work that needed to be done with the child of pre-school age. As a result of this, plans could be made by this advisory committee to develop the interest of the medical profession in these problems of educating the parent in the needs of the child of pre-school age. If the physicians of the community become interested in these problems of preventive medicine and sometimes curative medicine, and the parent and physician coöperate in meeting these problems, much of the work of the child in the school will have been taken care of and the problems of the school will be reduced. Greater effort then can be exerted in health education in the school.

You may wonder what some of these problems are. O'Neill and McCormick of New York report that 43 per cent of school children show evidence of over fatigue; 70 per cent eat not more than one egg a week; 18 per cent eat no fruit; 74 per cent of older children eat candy excessively at home and between meals; two-thirds of children commonly use laxatives; 35 per cent of all and 70 per cent of older children attend movies once a week; 27 per cent have mental maladjustments. In New York, five thousand people develop need for mental hospital every two years.

In addition to these problems of the child which the physician should understand in order to properly advise the patient, there is the problem of immunization early in life before the child attains school age, the correction of the defects found, and frequent physical examinations of the child by its own doctor. If the physician does this work he will have relieved the load of the school health department greatly, the work to be carried on in the future will be less, and the work with the child in school will be much easier since the parent will understand what it is all about.

A very admirable method of broadening the experience, understanding and sympathy of school work was developed in the city of Detroit where certain young physicians were employed one day a week in connection with the school health program.

Their employment only continued for two years, one-half of them leaving each year. In this way there was constantly a new group of physicians becoming familiar with school work and also a group going out into private practice or continuing in private practice with a much better understanding of school work.

There will, of course, be many medical problems which will come up with the child in school, who then may be referred to its own doctor, the doctor knowing what is expected of him.

One of the criticisms which may be made of this outline for a program will be that no provision is made for the care of and correction of defects in the child who is unable to pay for it. It is my opinion that it is the business of the school organization to educate the child in health matters and to find potential defects but not to make a diagnosis or to correct the defects. It is the business, however, of the schools to see that these people get into the proper channels for their examination, diagnosis and correction. If, as a result of the program worked out, it is found there are any number of children in school who are not hav-

ing their defects corrected or unable to get the medical care required, it is the business of the medical profession in that community to develop proper plans to see that the proper care is available.

I have purposely avoided development of a definite school health program to meet the needs of the schools, but have endeavored rather to point out the way to develop the machinery for the formation of plans and programs and to point out means of perfecting the organization which will be charged with the development of plans and obtaining the results.

In conclusion, it is my opinion that the proper school program, or any other health program, requires the confidence and co-operation between all parties concerned with it. There should be no disagreements between the medical profession and the school health authorities. There must be a thorough knowledge by all concerned as to what the aims of the program are and every fair effort must be put forward to place the program foremost in the objective, and the whole program must be carried on, on a strictly ethical basis.

## THE VENEREAL DISEASE PROBLEM, ITS PREVENTION AND CONTROL IN INGHAM COUNTY, MICHIGAN\*

A. J. ASELMEYER, M.D.

Surgeon, U. S. Public Health Service

and

LIDA J. USILTON

Statistician, U. S. Public Health Service

Several years before the awakening of the Nation to syphilis as a major health problem, a group of private physicians in Ingham County, Cichigan, had sought to arouse interest in the prevention and control of this disease in their own community. A public health committee had been appointed which secured from the entire membership of the Ingham County Society information on the individual physician's interest in venereal diseases, his willingness to treat syphilis and gonorrhea, and the success of his efforts in detecting the infection in its early stages.

\*The final meeting for the year of the Ingham County Medical Society took place in May. The event was a symposium based on an exhaustive study of the syphilis problem in Ingham County. Three papers were presented which are here published. The first embodies a study by Dr. A. J. Aselmeyer, Surgeon of the United States Public Health Service; the second, a paper by Dr. H. L. Keim of Detroit, on the application of the survey to the private practitioner; and the third, a paper by R. S. Breakey of Lansing, on the program for control of genito-infectious diseases in Ingham County. As a prelude to the meeting, short discussions were made by Dr. Henry Cook, president of the Michigan State Medical Society, Dr. Loren Shafer, chairman of the State Committee on Syphilis Control, and Dr. Don W. Gudakunst, Commissioner of Health for the State of Michigan. This number of THE JOURNAL contains a paper by Dr. Harold R. Roehm of Oakland County Medical Society on the survey of syphilis in Oakland County for 1937.

—EDITOR.

Armed with these basic facts, the Public Health Committee requested the Surgeon General of the United States Public Health Service to coöperate with them in establishing the prevalence and incidence of these diseases in Ingham County and in evaluating existing facilities for their prevention, detection, and treatment.

Part I of this report makes available these factual data on the syphilis and gonor-



rhea problem in Ingham County and appraises the existing detection, prevention, and treatment facilities.

Part II of this report presents a program

hundred thirty-six additional individuals with syphilis were discovered. Routine blood testing became a reality. Courage was essential to put into action such a procedure.

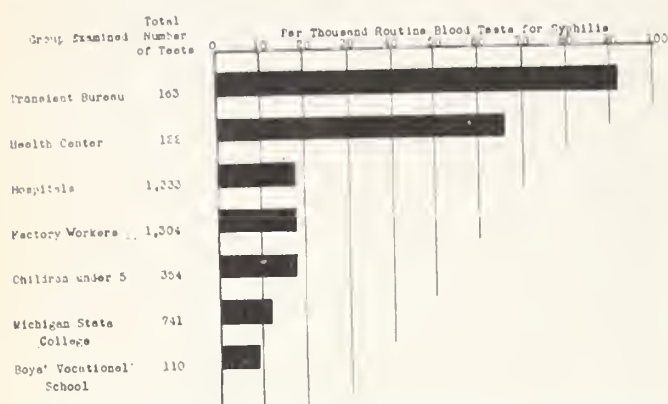


Fig. 1. Positive blood tests for syphilis per 1,000 routine examinations of the blood during a sixty day period, Ingham County, Michigan.

for the control of venereal disease. This program is submitted by the Public Health Committee to the Ingham County Medical Society for consideration and recommendations. It was designed to secure for the public, adequate protection against the spread of venereal disease by infected individuals and for the individual patient, adequate treatment, skilled medical care, and maximum privacy.

## PART I

### Methods Employed in the Survey

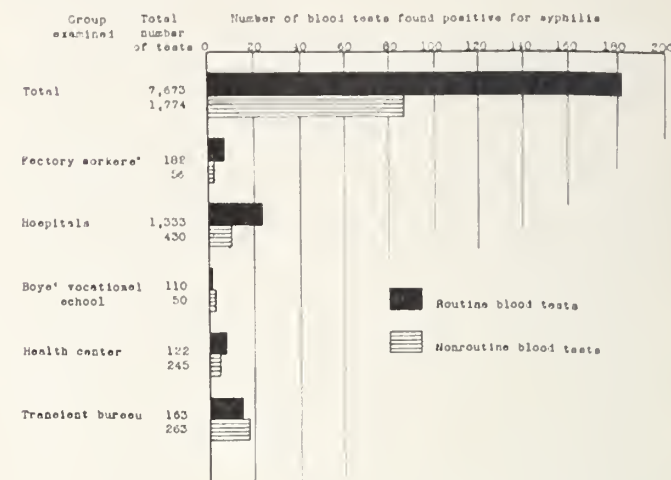
Two methods were proposed for establishing the extent of the venereal disease problem.

1. A novel plan, that of a routine blood test on all patients coming under the care of each private physician in active practice in Ingham County during a sixty-day period (January 15 to March 15, 1938).
2. A census of cases of venereal disease actually under treatment or observation by any authorized source of treatment within a given period (September 15, 1937, to January 15, 1938, for syphilis) and (December 15, 1937, to January 15, 1938, for gonorrhea).

The use of these two methods offers an opportunity to establish the ratio of under-treatment infected individuals to the potential treatment load.

#### 1. Routine blood tests.—

The plan of making routine blood tests on all private patients within a given period met with the approval of the entire membership of the Ingham County Medical Society. Splendid coöperation was obtained. Some 7,600 bloods were examined in a period of two months, as compared with 1,770 in the preceding two months. Two



\* Omitting Reo Plant, in which no tests were made before survey

Fig. 2. Absolute number of blood tests found positive on routine examination of certain groups compared with results from nonroutine blood tests.

Previously, blood tests had been made only on private patients for diagnostic or treatment control purposes. No one knew how much syphilis was hidden. Early in the operation of the plan the physician learned that the average American citizen offered no objection to the examination of his blood. These pioneers have led the way to the most effective present-day method of uncovering hidden sources of infection.

The number of individuals actually under treatment or observation for syphilis represented only one-sixth of the potential treatment load for the disease as detected through the serologic survey.

In Figure 1 is shown the rate of positives per 1,000 bloods tested in various groups of individuals. The amazingly high rate of positive bloods among individuals in transient camps lends some credence to the often repeated statement that much of the syphilis in our community is brought in from neighboring states; that to be won, the syphilis war must be waged on "forty-eight state fronts." In practically every group tested, at least one out of a hundred had evidence of syphilis.

The effectiveness of the routine blood test in detecting syphilis is apparent from a comparison of those uncovered in the present survey period with those found prior to the survey. Figure 2 makes an eloquent plea for the continuation of routine blood testing for syphilis.

Since the average number of patients seen by each private physician was unknown to the investigators, it was necessary to show the absolute number of persons examined

period sixty days prior to the survey has not been presented. There was an insufficient number of bloods examined to substantiate the apparently erratic changes in

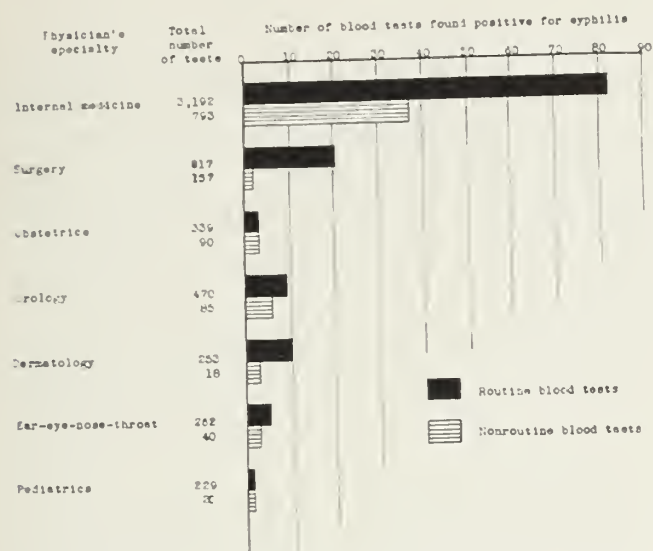


Fig. 3. Absolute number of blood tests found positive on routine examination by physicians in specialized groups compared with results from nonroutine blood tests.

and found positive with the total number tested as the base. Furthermore, it was impossible to say to what extent the tests were actually routine. However, there is sufficient evidence to indicate that there was certainly not the usual selection in patients for blood tests that existed prior to the survey period.

Figure 3 was designed to bring out the value of routine testing of blood for syphilis regardless of the physician's special field of medicine or surgery. In practically every branch of medicine the physician found a larger number of infected individuals than he had in a similar period in which the blood tests had not been a routine procedure.

While the prevalence rates for syphilis per 1,000 population reach a plateau about age twenty-five and begin to decline at about age forty-five,\* the proportion of positive bloods in the survey shows a general upward trend with increasing age. The prevalence rates are based on cases actually under treatment. The increase in the rate of positive bloods per 1,000 bloods examined results either from an over-accumulating number of persons completely neglecting treatment or else lapsing from treatment before they receive sufficient therapy to reverse the blood test to negative.

The curve for positive blood tests for syphilis based on those examined in the

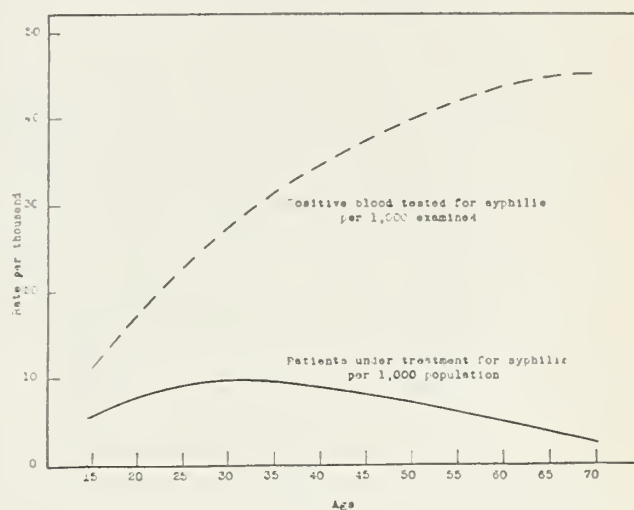


Fig. 4. Frequency of syphilitics detected by routine blood tests in given age groups compared with those under medical care.

TABLE I. POSITIVE BLOOD TESTS PER 1,000 BLOODS EXAMINED DURING SEROLOGIC SURVEY AND IN PRECEDING PERIOD AND THE RATE PER 1,000 POPULATION IN GIVEN AGES UNDER TREATMENT OR OBSERVATION FOR SYPHILIS, INGHAM COUNTY, MICHIGAN, 1938

Age	During Serologic Survey	Preceding Serologic Survey	Rate per 1,000 population under treatment or Observation for Syphilis
	Rate per 1,000 bloods examined		
0-4	17.8	16.3	1.5
5-9	—	—	.5
10-14	—	*	1.3
15-19	8.7	35.7	3.0
20-24	13.6	42.4	6.0
25-29	20.8	71.5	6.7
30-34	31.1	33.5	5.8
35-39	24.0	48.9	6.5
40-44			
45-49			
50-54	39.1	74.8	5.5
55-59	34.1	38.3	2.7
60-64			
65-69			
70-74	48.9	63.1	.9
75	—	—	.5

\*The small number of persons in age group 10-14 make the rates for positive bloods too unreliable; therefore, they have been excluded.



the percentage of positive tests found in given ages. In the curve based on the blood tests made during the survey period some reservation must be made, since the total patient population for which these blood tests were made, were not available to the investigators. The results are presented with the hope that other surveys of a similar nature will be made which may confirm these findings. It is of interest to note that the percentage of positive blood tests found among applicants for marriage licenses since the enactment of the Michigan antenuptial physical examination law on October 29, 1937, tends to confirm the results obtained in the serologic survey period. In the three months following the passage of the act, 5,693 of these applicants were examined in the Michigan Department of Health Laboratory, seventy-nine or 1.4 per cent of whom were positive. These data represent approximately one-half of the applicants for marriage licenses in Michigan during the reported period.

In Table I the rates for positive bloods in both the survey period and that preceding it, are shown. The prevalence rates per 1,000 population for syphilis are also shown. If blood tests were performed more than once for the same individual during the survey periods, they were excluded from the study.

2. *Results of the census of patients with venereal disease actually under observation and treatment.*—In Ingham County the number of individuals found actually under observation and treatment for venereal dis-

TABLE II. ANNUAL ATTACK RATE FOR GONORRHEA PER 1,000 POPULATION, INGHAM COUNTY, MICHIGAN, 1938

Stage of Gonorrhea on Admission	WHITE					
	Male		Female		Total	
	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000
Acute	684	11.5	96	1.7	780	6.7
Chronic	180	3.0	48	.8	228	1.9
Complications	24	.4	36	.6	60	.5
Total	888	14.9	180	3.1	1068	9.1

No new cases of gonorrhea among Negroes reported.

ease exceeded by 40 per cent those who were reported to the state health authorities. The incompleteness of current reporting of cases of venereal disease to the health departments limits the effectiveness of a preventive and control program, first, because without the knowledge of the extent of the disease it is impossible to secure an allocation of funds commensurate with the prevalence of venereal disease in relation to other communicable diseases; second, that it destroys the opportunity for the early detection and treatment of probable sources and exposed contacts; third, it prohibits the return of lapsed patients to the physician and thereby creates a dangerous and hidden source of infection through mucocutaneous relapses in inadequately treated syphilitics.

TABLE III. ANNUAL ATTACK RATE FOR SYPHILIS PER 1,000 POPULATION, INGHAM COUNTY, MICHIGAN, 1938

Stage of Syphilis on admission	WHITE				COLORED				Total	
	Male		Female		Male		Female			
	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000	Pa-tients	Rate per 1,000
Congenital	9	.15	27	.5	6	7.0	3	4.2	45	.4
Early	69	1.2	78	1.4	18	21.0	12	17.0	177	1.5
Latent	90	1.5	45	.8	9	10.5	6	8.5	150	1.3
Neurosyphilis	36	.6	18	.3	—	—	—	—	54	.5
Late unspecified and other	108	1.8	51	.9	—	—	—	—	159	1.3
Total	312	5.2	219	3.8	33	38.4	21	29.7	585	4.9

No new cases of cardiovascular syphilis detected during survey period.

The annual attack rate for gonorrhea in this community is 9.1 per thousand, and for syphilis, 4.9 per thousand. These rates include both early and late cases seeking

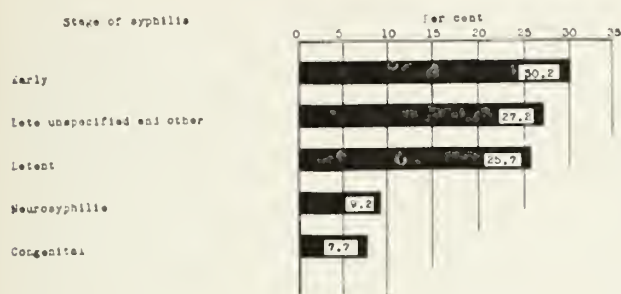


Fig. 5. Proportion of patients in various stages of syphilis admitted to treatment for the first time during the year 1937, Ingham County, Michigan.

treatment for the first time for their infection. The attack rate for acute gonorrhea is 6.7 per thousand, that for early syphilis 1.5 per thousand, which is no higher than the rate found through surveys of other comparable communities.

These rates become a living drama when expressed in individuals. Seven hundred and eighty individuals acquire gonorrhea each year among the 118,000 individuals of Ingham County, and another 177 acquire syphilis. As is shown subsequently in this report, through inadequacy of treatment, two out of three of these individuals will be added to the ever-accumulating load of potential treatment problems of the next decade. Urgent need for more alertness in the detection of syphilis in pregnancy is evidenced by the failure to give thirty mothers sufficient treatment to prevent the transmission of syphilis to the child during a one-year period.

From an economic standpoint these children are not the only toll which syphilis exacts from the community. There is the patient who has neglected to seek treatment during the early stage of the disease and seeks the physician only when his infection has progressed to cardiovascular or central nervous system syphilis. This latter group forms 9 per cent of those who sought treatment during the year.

The rate for syphilis is higher in the white male than in the white female. The rate for the colored race is approximately six times that for the white race. However, the treatment of the negro is a minor problem because this group of individuals form only slightly over 1 per cent of the population of Ingham County.

TABLE IV. DISTRIBUTION OF PATIENT POPULATION UNDER TREATMENT FOR VENEREAL DISEASE BY ALL SOURCES BY RACE AND SEX, INGHAM COUNTY, MICHIGAN, 1938

Race and Sex of Patient	Number of Patients	Percentage Distribution	Prevalence Rate per 1,000
White male	393	57.0	6.6
White female	256	37.2	4.5
Colored male	22	3.2	25.6
Colored female	18	2.6	25.5
Total	689	100.00	5.8

TABLE V. DISTRIBUTION OF PATIENT POPULATION UNDER TREATMENT FOR VENEREAL DISEASE BY RESIDENCE, INGHAM COUNTY, MICHIGAN, 1938

Residence of patient	Number of Patients	Percentage Distribution
Lansing	546	79.2
Ingham County	100	14.5
Out of County	43	6.3
Total	689	100.0

Seventy-nine per cent of the patients with syphilis and gonorrhea reside in Lansing. This percentage of distribution approximates that of the general population.

The prevalence rates for syphilis and gonorrhea which indicate the constant patient population under treatment or observation for these infections in Ingham County are 3.8 per 1,000 population for syphilis and 1.9 for gonorrhea. The rate for early syphilis is 1.2 and for acute gonorrhea is 1.1.

Although 82 per cent of the patients with venereal disease were in the hands of 31 per cent of the physicians in Ingham County, only a third of the physicians had no patients under treatment. It is apparent that the physicians in general in this community are syphilis conscious. Further evidence that the physicians of Ingham County have a "high index of suspicion" is revealed by the fact that 30 per cent of the patients under treatment for syphilis were in the early stages of the infection on admission.

A study of the physicians classified by the branch of medicine or surgery which they practice showed that 27 per cent of the gen-



TABLE VI. CONSTANT PATIENT POPULATION UNDER TREATMENT OR OBSERVATION FOR SYPHILIS AND GONORRHEA, INGHAM COUNTY, MICHIGAN, 1938

Stage of Infection on Admission	Number of Patients	Rate per 1,000 Population
Syphilis:		
Congenital	46	.39
Early	149	1.26
Latent	115	.97
Cardiovascular	3	.02
Neurosyphilis	35	.30
Late, unclassified	111	.94
Total syphilis	459	3.87
Gonorrhea:		
Acute	141	1.19
Chronic	69	.58
Complications	20	.17
Total gonorrhea	230	1.94

eral practitioners treated no cases; 33 per cent of the surgeons and 60 per cent of the obstetricians. The ultimate control of syphilis is assured, provided every practicing physician is constantly on the alert to detect the early case. This is fundamental to the success of any program designed to prevent and to control syphilis.

Although the early detection of syphilis is of paramount importance, the gains made are quickly lost if the physician fails to hold the patient under treatment until he has been rendered noninfectious and protected against a disastrous outcome from the disease. Unfortunately, just this situation exists in Ingham County. Despite the fact that a higher proportion of patients have been detected in the early stages of syphilis in this county than in most communities throughout the Nation where surveys have been made, only one out of three of the patients have received the minimum required treatment to render them noninfectious before they disappear. This low percentage of individuals receiving prescribed therapy is due not only to the high percentage of individuals who disappear from treatment before they have been adequately treated but also because those who remain under treatment fail to adhere to a continuous schedule of therapy. Approximately one-half of the patients pursue a haphazard treatment schedule interspersing long lapses in the all-important

TABLE VII. DISTRIBUTION OF PATIENTS WITH VENEREAL DISEASE BY PHYSICIANS, INGHAM COUNTY, MICHIGAN, 1938

No. of Patients	Total Patients		Number of Physicians	
	Number	Per Cent	Number	Per Cent
None	00	00	46	35.4
1-4	98	17.9	44	33.8
5-9	158	28.8	24	18.5
10-14	69	12.6	6	4.6
15-19	85	15.4	5	3.8
20-29	100	18.2	4	3.1
30-39	39	7.1	1	.8
Total	549	100.0	130	100.0

NOTE—31 per cent of the physicians treat 82 per cent of the venereal disease patients.

TABLE VIII. PROPORTION OF PHYSICIANS IN VARIOUS BRANCHES OF MEDICINE OR SURGERY WHO HAD NO CASES OF VENEREAL DISEASE UNDER TREATMENT DURING THE SURVEY PERIOD, INGHAM COUNTY, MICHIGAN, 1938

Branch of Medicine or Surgery	Number of Physicians in Group	Number of Physicians Reporting no Cases	Percentage Distribution of Physicians Reporting no Cases
Internal Med.	75	20	26.7
Surgery	15	5	33.3
Obstetrics	5	3	60.0
Proctology	2	1	50.0
Urology	5	1	20.0
Dermatology	1	—	—
Eye, ear, nose and throat	12	9	75.0
Pediatrics	5	3	60.0
Neurology	1	—	—
Radiology	1	1	100.0
Total	122*	43	35.2

\*This table includes physicians with private practice only.

first two years of the infection. This is true of patients under the care of either the private physician or the public clinic.

A study was made of the economic status of patients with syphilis and gonorrhea. It was found that two-thirds of the patients seeking treatment for early syphilis in Ingham County were on a low economic level. In fact, only 9 per cent of the early syphil-

# VENEREAL DISEASE PROBLEM—ASELMEYER AND USILTON

TABLE IX. TREATMENT GIVEN PATIENTS WITH EARLY AND LATE SYPHILIS BY PRIVATE PHYSICIANS AND IN THE CITY CLINIC IN LANSING, DURING INDICATED PERIODS OF TREATMENT, INGHAM COUNTY, MICHIGAN, 1938

Amount of Treatment	PERIOD OF ADMINISTRATION							
	1-2 Years		2-3 Years		3 Yrs. or More		Total	
	Early	Late	Early	Late	Early	Late	Early	Late
Private Physicians								
Heavy metal only	—	3	1	†	—	—	1	3†
Arsphenamine injections*								
1- 4	1	—	—	1	1	1	2	2
5- 9	—	—	—	2	2	2	2	4
10-14	2	3	—	4	—	4	2	11
15-19	—	5	—	3	—	2	—	10
20 or more	6	10	4	7	1	12	11	29
Total	9	21	5	17†	4	21	18	59†
City Clinic and Others								
Heavy metal only	1	1	4	1	4	2	9	4
Arsphenamine injections*								
1- 4	—	1	—	—	3	2	3	3
5- 9	2	—	—	1	2	1	4	2
10-14	1	—	1	—	3	3	5	3
15-19	1	—	1	1	4	2	6	3
20 or more	—	—	2	—	1	3	3	3
Total	5	2	8	3	17	13	30	18

\*The injections of arsphenamine are used as the index; the amount of interim heavy metal is not shown.

†Excluding oral administration to three patients.

TABLE X. COMPARISON OF THE SYPHILITIC PATIENTS WHO ARE STILL UNDER TREATMENT BY PRIVATE PHYSICIANS AND IN PUBLIC CLINICS WITH THOSE WHO ARE NO LONGER UNDER TREATMENT, SHOWING THE AMOUNT OF ARSPHENAMINE ADMINISTERED DURING SPECIFIED TREATMENT-OBSERVATION PERIODS

Duration of Treatment and observation in Years	PHYSICIANS					CLINICS AND OTHERS				
	1 to 19 Injections		20 or more Injections		Average	1 to 19 Injections		20 or more Injections		Average
	Number	Per Cent	Number	Per Cent	Inject.	Number	Per Cent	Number	Per Cent	Number Inject.
	Still Under Treatment									
Less than 1 year	110	81.5	17	31.5	11	61	68.5	1	16.7	7
1- 2 years	10	7.4	15	27.8	21	4	4.5	—	—	8
2- 3 years	5	3.7	10	18.5	25	4	4.5	2	33.3	17
3 years or longer	10	7.4	12	22.2	26	20	22.5	3	50.	13
Total	135	100.0	54	100.00	15	89	100.0	6	100.0	9
	No Longer Under Treatment									
Less than 1 year	19	67.9	—	—	8	10	71.5	—	—	4
1- 2 years	2	7.1	1	33.3	18	2	14.3	—	—	12
2- 3 years	5	17.9	1	33.3	16	1	7.1	—	—	16
3 years or longer	2	7.1	1	33.3	23	1	7.1	1	100.0	18
Total	28	100.0	3	99.9	12	14	100.0	1	100.0	8



TABLE XI. ECONOMIC STATUS OF NEW PATIENTS WITH SYPHILIS OR GONORRHEA, INGHAM COUNTY, MICHIGAN, 1938

Economic Status	SYPHILIS				Gonorrhea	
	Early		All Other Stages			
	Number	Per Cent	Number	Per Cent	Number	Per Cent
On relief	31	47.7	38	29.2	13	14.6
Poor	12	18.5	26	20.0	23	25.8
Moderate	16	24.6	49	37.7	40	45.0
Good	6	9.2	17	13.1	13	14.6
Total	65	100.0	130	100.0	89	100.0

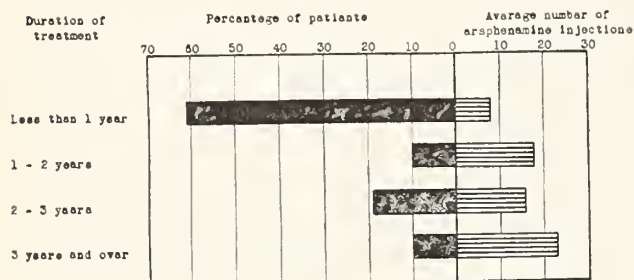


Fig. 6. Number of injections of arsphenamine with interim heavy metal administered by private physicians to 31 patients who disappeared, showing period of treatment, Ingham County, Michigan.

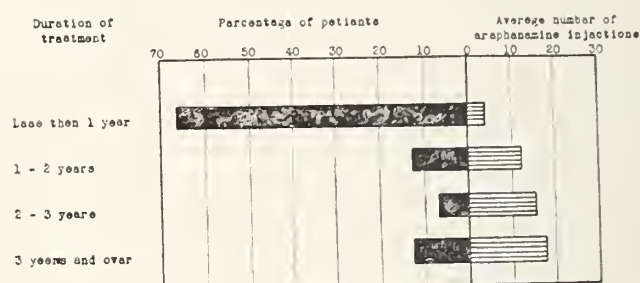


Fig. 7. Number of injections of arsphenamine with interim heavy metal administered by public clinics to 15 patients who disappeared, showing period of treatment, Ingham County, Michigan.

itics had an earning capacity of \$3,000.00 per annum. A comparison was made of the economic status of early syphilitics with that of the forty-five million wage earners of the United States, as reported in "America's Capacity to Consume" by the Brookings Institute. It was found that the economic status of the two groups was similar. Thus, for every patient with syphilis who can afford to pay the private physician there are nine other syphilitics who cannot afford this care in the early stages. In the late stages of syphilis a higher proportion of those infected have moderate or good economic status. It is unfortunate that once an individual has a sufficient earning capacity to pay for the treatment of syphilis, the disease has passed beyond the stage when modern therapy can offer the greatest promise of "cure."

With gonorrhea, the average duration of treatment is shorter and therefore the cost is less so the economic status of the patient is not so important a factor in the control of this disease.

## Present Detection and Treatment Facilities

Blood tests for syphilis as performed in the Michigan State Laboratories were found reliable both as to specificity and sensitivity by the United States Public Health Service Committee on Evaluation of Serodiagnostic Tests. The performance of blood serologic tests is not restricted to State Laboratories. Privately owned laboratories are registered and a control maintained on their accuracy in serodiagnostic work through the examination of unknown sera supplied approximately four times a year by the Michigan State Laboratory. Licenses are withdrawn whenever the private laboratories fail to meet the standard requirements of the State. The Michigan Department of Health provides Kahn antigen to all registered laboratories without charge.

In the present serologic survey, January 15 to March 15, 1938, the Michigan State Laboratory performed 88 per cent of the examinations. However, of the 360,000 serodiagnostic tests performed last year in Michigan 79 per cent were made by regis-

tered laboratories. Improved apparatus for delayed darkfield tests for syphilis recently have been made available. A very limited number of spinal fluid examinations are made.

## PART II

### State of Michigan Control Measures for Venereal Diseases

Act 272 P. A., 1919, was designed to protect the public health; to prevent the spreading of venereal diseases, to prescribe the duties and powers of the State Department of Health and of local health officers and health boards with reference thereto and to make an appropriation to carry out the provisions of this act. The State Department of Health, in carrying out the provisions of this act, requires from every treatment source an immediate report of every patient with syphilis, gonorrhea, or chancroid on blanks prepared and furnished to physicians and health officers for this purpose. To facilitate the proper treatment of infected individuals the State Department of Health makes available to physicians on request arsenicals and bismuth for the treatment of reported patients with syphilis provided the patient is unable to pay a sufficient fee to include the cost of drugs. This same provision for drugs is made to hospitals and clinics.

The distribution of drugs is the function of the State Department of Health. However, in those counties where a full-time county health unit is in operation the local health officer distributes drugs to treatment sources within his jurisdiction. Fifty-six of the eighty-three counties in Michigan have a full-time county health unit. Plans have been approved for the establishment of two additional county health units, one of which will be in Ingham County. This county health department is to be used as a field demonstration and teaching center for physicians taking postgraduate courses in Public Health at the Wayne University and University of Michigan.

A further function of the county health officer is the follow-up and return to treatment of those patients who discontinue therapy before receiving the minimum amount required to prevent the spread of the infection in the community. The State Department of Health has one field investigator assigned for follow-up service in those counties in which a health unit has not been

established. During the past year the physicians in the rural area of Ingham County reported five patients delinquent from treatment, all of whom were returned and three exposed contacts, all of whom were examined, found to be infected, and placed under treatment. The success of this type of follow-up is largely dependent on the coöperation of physicians in reporting delinquent cases and probable sources and exposed contacts for investigation. Evidence that this type of follow-up is not wholly effective is found in the facts that only one out of three of the syphilitics under treatment by authorized medical sources sought care in the early stages of the disease, and further that only one out of three of those under treatment remained a sufficient time to receive enough treatment to render him noninfectious.

Since September 1, 1937, a full-time venereal disease control officer has been assigned to direct the program under the Bureau of Communicable Diseases. One of the objectives of the present plan of the Health Commissioner is to foster short review courses in current diagnostic and treatment practices in venereal diseases for the private physician.

A separate venereal disease control unit has been established in the City of Lansing under the direction of the City Health Department. This unit provides a venereal disease clinic for the treatment of the medically indigent. Treatments for persons infected with syphilis are given once each week, on Saturday mornings. Treatment of persons infected with gonorrhea are carried out five mornings per week in conjunction with other general medical care. No provision has been made for a separate prenatal clinic. However, routine serologic blood tests are made on all pregnant women. There are no evening clinics for the treatment of venereal disease. There is no adequate medical social follow-up available to this clinic. Evidence of the need for such service is found in the analysis of the performance of this clinic with regard to tracing the probable sources and exposed contacts and the inability to hold patients until they have received enough treatment to prevent the spread of the infection in the community.

Provision has been made by the city to treat those transients who are infected with syphilis. Every overnight transient is given a serologic blood test and an examination



for gonorrhea. The treatments for gonorrhea are given at the transient camp. Notification of the identity of all infected individuals is made to all camps for transients in the state.

Individuals in need of hospitalization because of venereal disease are admitted to the hospitals in the city of Lansing. Quarantine facilities at the City Contagious Hospital are available for the control of recalcitrant infectious individuals who persistently refuse to take or resume treatment.

The city of Lansing does not operate a municipal hospital for the general medical and surgical care of the indigent. Hospitalization of the indigent sick is provided for on a per diem basis in the two privately owned hospitals. These patients are given general medical and surgical care by the members of the Ingham County Medical Society. The society receives reimbursement for these services in accordance with an agreement with the City Board of Directors. In turn, the society offers certain privileges to its members payable from these funds. Under this plan, hospitalization for the indigent sick has been reduced to an average of five days per patient. Blood tests are made in these institutions whenever the physician requests this service. Therefore, they are not routine. During the serologic survey period routine blood tests were performed.

### Summary

A public health committee of the Ingham County Medical Society requested the cooperation of the United States Public Health Service in determining the extent of the problem of venereal diseases in Ingham County. The committee proposed two methods for establishing the prevalence and incidence of these diseases:

1. A novel plan, that of a routine blood test on all patients coming under the care of each private physician in active practice in Ingham County during a sixty-day period (January 15 to March 15, 1938).

2. A census of cases of venereal diseases actually under treatment or observation by an authorized source of treatment within a given period (September 15, 1937, to January 15, 1938, for syphilis, and December 15, 1937, to January 15, 1938, for gonorrhea).

Through these two methods it was proposed to establish the ratio of under-treat-

ment patients with syphilis to the potential treatment load.

During the two-month survey period the private physicians examined 7,600 bloods, as compared with 1,770 in the preceding two months. One hundred additional persons with syphilis were uncovered through the routine serologic survey.

The percentage of positives in the routine serologic survey was 2.4, as compared with 4.8 in the preceding sixty-day period. Naturally, the rate in the preceding sixty days was higher, since blood examinations were more or less limited to individuals in whom syphilis was suspected.

The results of the one-day census survey indicated that 3.9 per thousand individuals with syphilis were constantly under observation and treatment by an authorized medical source. Only one out of six persons in whom syphilis could be detected by a routine blood test was actually under observation and treatment for the disease.

In practically every branch of medicine or surgery a larger number of infected individuals were detected by the use of a routine serologic blood examination during the survey period than had been in a similar period in which the examination of the blood had not been a routine procedure.

The prevalence rates for syphilis per thousand population reach a plateau about age 25 and begin to decline at about age 45. The proportion of positive bloods in the survey shows a general upward trend with increasing age. The increase in the rate of positive bloods per 1,000 bloods examined results either from an ever-accumulating number of persons neglecting treatment or else lapsing from treatment before they receive sufficient therapy to reverse the blood test.

The annual attack rate for gonorrhea in this community, based on fresh infections seeking treatment, is 6.7 per thousand; that for early syphilis, 1.5 per thousand population. Annually, at least 780 individuals acquire gonorrhea and 177 acquire syphilis of the 118,000 residents of Ingham County.

Urgent need for more alertness in the detection of syphilis in pregnancy was evidenced by the failure to give thirty mothers sufficient treatment to prevent the transmission of syphilis to the child during the one-year period.

Neglect in seeking treatment in the early

stage of the disease was evidenced by the fact that 9 per cent of those who sought treatment during the year had progressed to central nervous system syphilis.

The data indicate that the physicians of Ingham County had a "high index of suspicion." This statement is premised on the fact that a higher proportion of patients were detected in the early stages of syphilis in this community than has been found in most communities surveyed throughout the nation. However, it was found that physicians of Ingham County were no more successful in holding patients until they had received the minimum required treatment to render them non-infectious before they disappeared than had been found to be true elsewhere. The proportion of patients who received sufficient treatment was only one out of three. Furthermore, there was evidence that those who do secure enough treatment before disappearing fail to adhere to a continuous schedule of therapy. Ap-

proximately one-half of the patients pursue a haphazard treatment schedule, interspersing long lapses in the all-important first two years of the infection.

A study of the economic status of patients with syphilis and gonorrhea indicated that two-thirds of the patients seeking treatment for early syphilis in Ingham County were on a low economic level. In fact, only 9 per cent of the early syphilitics had an earning capacity of \$3,000 or more per annum. Thus, for every patient with syphilis who can afford to pay a private physician there are nine other syphilitics who cannot afford this care in the early stages. In the late stages of syphilis a higher proportion of those infected had moderate or good economic status.

With gonorrhea, the average duration of treatment is shorter and therefore the cost is less, so that the economic status of the patient is not so important a factor in the control of this disease.

## APPLICATION OF THE SURVEY TO THE PRIVATE PRACTITIONER

HARTHER L. KEIM, M.S., M.D.  
DETROIT, MICHIGAN

I am indeed pleased to be here and take part in this symposium, for I have the distinct feeling that medical history for the State of Michigan is in the making.

The obvious splendid coöperation, between the national, state and local health authorities and the Michigan State and Ingham County Medical Societies, foreshadows the adoption and workability of a venereal disease control program, which will be satisfactory to all concerned. This is in striking contrast to the apparent difficulties now encountered in a similar situation in a bordering state.

Judging from what has already been accomplished by this coöperative spirit and what is to be proposed later this evening, by your new Preventive Medicine Committee, there can be little doubt that in the not too distant future, a practical program will be in operation which will serve as a model for other units within the state, as well as beyond its borders, known, may I say, as, "The Ingham County Plan"?

The plan, when formulated and in operation, should recommend itself to all interested parties, namely: the Public (Public Health Agencies), the Patient, and the Private Physician.

### *The Public*

Will receive maximum protection. This will be secured by:

1. Modern treatment to reduce infectiousness.

2. Trained contact and medical follow-up personnel.
3. Lay education.
4. Active flexible file for the control of infected cases.
5. Coöperation of pharmacists to prevent counter prescribing.
6. Continuation of serologic diagnosis survey.
7. Reporting of all cases.

### *The Patient*

Will receive adequate treatment, skilled medical care, and maximum privacy. These will be secured by:

1. Financial support if necessary.
2. Postgraduate or refresher courses for physicians.
3. Routine serologic examination of every pregnant individual.
4. Available competent consultation.
5. Maximum privacy as can only be secured in the physician's office.

### *The Physician*

Retains control of his patient and the important patient-doctor relationship is maintained.



However, if we as physicians are going to accept this responsibility, and its success or failure rests with us, we will have to be prepared to render "skilled medical care," in the fullest meaning of the term. Either one should be prepared to treat these diseases according to present day standards, or decide not to include them in his practice. With the plan functioning, facilities will then exist for the Prevention and the Detection of the genito-urinary diseases and it will be up to the physician to furnish that brand of modern, adequate and skilled medical care that will, in the shortest possible time, render the patient noninfectious and protect him against later serious sequelæ.

This, then, brings me to my main theme, "The Modern Treatment of Syphilis." Because we are this evening primarily interested in the control of the genito-urinary diseases I will confine my remarks to the treatment of early infectious syphilis.

I have long felt that we as physicians are not only privileged, but duty bound, at the time the infection is discovered, to secure such understanding and coöperation from the patient that he will continue his anti-syphilitic therapy to a successful conclusion. This is the opportune time to gain the patient's confidence and mold his reactions and responsibilities to his new-found handicap. This can be accomplished by explaining to him in understandable terms the seriousness of his disease without frightening generalities; its communicability; his chance for cure; and what in time, effort and finance will be required of him to avoid unnecessary later accidents. Such time and effort on the part of the physician is usually well repaid, and even the less responsible group, with such an introduction to the disease, are more apt to continue long enough to at least decrease the probability of infectious relapse.

Impress upon your patient that early syphilis is curable. We know that occasionally the disease is self cured or cured with little treatment, but not knowing which cases may be resistant we must, of course, give all cases the benefit of a minimum amount of therapy.

### The Rôle of Arsenic, Bismuth and Mercury in Modern Treatment

Two metals, namely, arsenic and bismuth, properly administered over a sufficiently

long period of time, will bring to a successful conclusion the vast majority of all cases of early syphilis.

A few known facts about these medicants:

1. Arsenic is the controller of infectiousness.
2. Bismuth is the defensive mechanism stimulator.
3. Syphilis has been cured with either alone, but the margin of safety is too small.
4. Most satisfactory results are obtained by their alternate use.
5. Neoarsphenamine plus bismuth is now known to be as effective as old arsphenamine plus bismuth, the latter making up for the lesser arsenic content of neoarsphenamine.
6. Treatment systems including bismuth call for a dosage of 100 mg. of metallic bismuth per week. The insoluble salt is preferred.
7. Mercury has little or no place in the treatment of early syphilis.
8. Mapharsen is rapidly winning a place in the therapy of early syphilis.

### Some Principles of Modern Treatment

The time is well within my memory when syphilologists were apt to frown upon any attempt to routinize syphilis therapy. However, painstaking study over the past decade by the Coöperative Clinical Group, the United States Public Health Service and the League of Nations Syphilis Commission has given us a systematic schedule of early syphilis therapy, confirmed in principle and fact, which we are striving to have uniformly adopted by the profession. The present schedule of choice is the American system of continuous treatment, as opposed to the British intermittent treatment technic.

Recent re-examination of the Coöperative Clinical Group statistics reveals some of the reasons for the selection of the continuous system.

1. *Continuity of treatment*
  - a. Was found to be more effective than intermittent in all types of early syphilis.
    - (1) Fewer relapses (13% as opposed to 21%)
    - (2) Satisfactory results (2 yrs.) (79% as opposed to 65%)
    - (3) Serologic reversals in 1 yr. (82% as opposed to 37%)
    - (4) Latent syphilis-satisfactory results (49% as opposed to 37%)
  - b. Continuous treatment produces no more serious accidents than intermittent.
2. *There is no need to fear liberal dosage*
  - a. Full dosage no more toxic than reduced dosage
  - b. Full dosage more effective than over-cautious or reduced dosage.
  - c. Dosage should be determined by weight, not sex.
  - d. Average dose
    - 0.6 grams neoarsphenamine (0.45 to 0.75 grams)
    - 0.45 grams old arsphenamine

3. *Prolongation of treatment—(longer series)*
- a. Experience shows that longer series result in no more accidents than shorter courses.
  - b. Toxicity factor in modern systems is not a dosage or longer series factor. Rather:
    - (1) Faulty administration (too rapid)
    - (2) Extravasation of arsenical
    - (3) Idiosyncrasy
    - (4) Declining tolerance with passing of years
    - (5) Functional damage (syphilis or other causes)

### Continuous Treatment Schedules

Giving thought to the above facts, we can then proceed to systematize minimum treatment for early and latent or occult syphilis (i.e., positive blood test, no signs, no symptoms and a completely negative spinal fluid) in early and middle adult life with dosage by weight, no distinction between men and women, continuously administered with alternate but combined use of arsenical and bismuth, as less complicating inducing, than concurrent or simultaneous use.

The Coöperative Clinical Group recommends what has come to be known as the 30-60-0-3 minimum system. This refers to 30 injections of arsenical, 60 of bismuth, no rest period and three years' observation. It is a convenient way to remember the figures. Numerous modifications of this schedule are in vogue. Our own Advisory Committee on Syphilis Control with Dr. Shaffer as chairman prefers that arsenical 1, 2 and 3 be given during the first seven days, to be followed with five weekly intravenous injections of the arsenical and then alternate with courses of bismuth until 40 of each are given.

The recommended schedule for latency, i.e., syphilis after five years, follows the so-called 24-60-100 plus plan. Beginning with 8 weekly injections of arsenical, followed with 10 to 12 weekly injections of bismuth, the schedule is continued without rest period until the quota of 24 arsenicals is given. Conservatism would suggest inauguration of therapy in latency with bismuth rather than the arsenical, to avoid the possibility of shock in a patient with a hidden active lesion. The 100 plus refers to the continuation in selected cases of a course of heavy metal yearly, for three to five or even ten years, which definitely helps the ultimate result.

Such procedure (24-60-100 plus) in latency reverses 70 per cent of positive blood tests, reduces probability of progression from 20 to 30 per cent to 2.5 per cent. The

time in life that one should modify this schedule does not depend upon the patient's years, but upon the individual's state of health and probable ability to tolerate the treatment.

### Syphilis in Pregnancy

Another important division of the practicing physician's syphilis problem is that of the pregnant patient. It is obviously not possible here to outline the equivalent of the above schedules, but the following recommendations should be included in the management of every pregnant syphilitic.

1. Serologic examination of the blood should be done before the fifth month if possible.
2. Begin treatment when possible before the fifth month (91 per cent healthy children against 61 per cent when treatment is begun later)
3. Every infected woman should be treated through every pregnancy, whether blood is positive or negative.
4. Have syphilitic mother limit her family so as to avoid accumulative over treatment.
5. Estimated tolerance of the woman for treatment must be individually determined, not routinized.
6. Remember that the pregnant woman tolerates arsenicals better than the nonpregnant syphilitic woman (one-half as much dermatitis and one-fifth as much jaundice)
7. Try for Coöperative Clinical Group minimum of 10 arsenical and 10 bismuth injections.
8. Prefer alternate continuous treatment, but if time is short, give simultaneously, provided mother's condition is good and elimination unimpaired.
9. End treatment before delivery with an arsenical injection. Then continue postpartum to satisfactory conclusion with one of the continuous schedules.
10. Frequent urine and blood pressure examinations.
11. No induced abortions, no lumbar puncture until after delivery.
12. Postpone malaria, tryparsamide or other special treatment until after delivery.
13. Use child's tenth day own blood for serologic test (jugular vein), not cord blood.
14. X-ray of fetal bones and microscopic examination of placenta should be utilized in doubtful cases.

Spinal fluid examination is essential to the intelligent management of every case of syphilis treated. In early and latent syphilis this examination should be made at the completion of the first arsenical course, six to eight weeks after the inauguration of intravenous therapy. This allows some time to gain the patient's confidence and alter his prejudice against this procedure.



The prognostic grading of spinal fluids divides itself into: 90 per cent of these serious arsenical accidents are preceded by one or more minor

(after Stokes)

GRADE	I (MILD)	II (MODERATE)	III (SEVERE)
BLOOD	Negative or Positive	Negative or Positive	Almost invariably strongly positive
CSF QUANTITATIVE WASSERMANN	Negative 0.2 c.c. to 1.0 c.c.	Negative 0.2 c.c.; Positive 1.0 c.c.	Strongly positive 0.2 c.c. to 1.0 c.c.
CELLS	5 to 25	25 to 100	7 to 100 plus
PROTEIN	1 plus	2 plus	3 plus
COLLOIDAL TEST	1110000000 0000011000	00244543100	5555543100
PROGNOSIS	Clears with standard or routine treatment for the disease.	Requires 1 to 2 years additional standard. plus intra-spinal or fever.	Will not clear without fever or tryparsamide, or both.

Moderate or severe spinal fluid findings which do not respond to routine treatment warrant consultation and specialized management. It is axiomatic that no case of syphilis can be discharged as cured without spinal fluid examination.

Reactions to arsenical medication unavoidably accompany syphilis therapy, but careful attention to administration and to patient will not only reduce the number of such accidents, but likewise their severity. Grave reactions frighten and alter therapeutic procedure, minor disturbances lead to lost confidence, lapse in treatment schedule, prolonged infectiousness and unsatisfactory final results.

Grave reactions are definitely preventable. Attention to intercurrent, focal and skin infections, all of which tend to broaden the allergic base, will definitely improve the patient's arsenical tolerance. Approximately

disturbances, which, if recognized, should serve as danger signals. Gastro-intestinal upsets, itching, urticaria, slight rashes, and the like should induce cautious therapy and prevent the administration of that last injection which may throw the patient into one of those dreaded arsenical mishaps.

Finally, let me say again that the success or failure of this ambitious plan for the control of the genito-urinary diseases in Ingham Country rests with the practicing physician. This is particularly true of the epidemiologic control of these diseases, the newest form of attack upon the infectiousness problem. As I said before, it begins at the time of the first office visit when the seed is sown for a coöperative doctor-patient relationship, which will not only result in sustained therapy, but will furnish us with information to make possible successful contact tracing at the hands of our proposed trained personnel.

#### The Patient Himself

The phenomenal advances of medical science have so largely engrossed the attention of students and teachers of medicine that our schools are charged frequently with failure to teach the embryo physician that his patients are human beings and that he must treat individuals, not merely manifestations of a disease. One of our leading universities has made a definite effort to counteract this tendency and their experience of seven years seems to have more than justified the undertaking. Elsewhere in this issue, Bailey and Weiskotten describe the procedure employed at Syracuse to demonstrate to undergraduate students the importance of considering the personality of the patient and all the factors, environmental and otherwise, which, impinging on him, inevitably influence and perhaps greatly modify his reaction to disease. Especially wholesome in the Syracuse plan is the stress on having the student himself investigate the social, economic, religious or industrial relationships of his patient instead of depending on the second hand information relayed by a social worker. On the doctor is laid the responsibility for understanding all the adjustments that may be needed in order to give to the patient the best possible chance of recovery. An index of the success of the method may be found in the work recently published by a Syracuse graduate, "Disease and the Man," which is briefly reviewed in this issue of THE JOURNAL.—*Jour. A. M. A.*, Dec. 25, 1937.

# PROGRAM FOR CONTROL OF GENITO-INFECTIOUS DISEASES IN INGHAM COUNTY, MICHIGAN

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Secretary, Preventive Medicine Committee  
LANSING, MICHIGAN

Submitted by the Public Health and Preventive Medicine Committee of the Ingham County Medical Society following consultation with the United States Public Health Service; the Commissioner of Health of the State of Michigan, D. Gudakunst; the director of Laboratories, C. C. Young; and the chairman of the Michigan State Medical Society Syphilis Control Committee. Grateful appreciation is herewith extended to the above departments and individuals as well as to the officers and the Council of the Michigan State Medical Society and the Lansing Department of Health for their invaluable assistance in making possible the survey presented.

This survey has been carried out by the Ingham County Medical Society as a whole, the original work having been begun more than two years ago. Recommendations submitted are based upon conclusions drawn from three particular viewpoints.

The Ingham County Medical Society is proud of the fact that nowhere else has there been made a survey of physicians by the physicians themselves, as was completed here eighteen months previously. They further take pride in the fact that they have themselves largely defrayed the expenses of the survey just completed. It must appear that the Society has indeed kept faith with the community and justified its original statement at the time of contractual relationship with local authorities in the care of the indigent sick, that monies received for such care would be used for the good of the people as a whole, as well as for the improvement of the standard of medical practice within the area involved.

The effort by which the Ingham County Medical Society has contributed both directly and indirectly is indeed unique. However, it must appear a waste of effort, time, and funds should not an endeavor be made to correct or eradicate such flaws as may have been uncovered.

With the facts now available it is possible to plan a program and to seek funds with which to carry forward not only the detection of these diseases under consideration but to insure a procedure of adequate treatment, and we urge your earnest consideration of the following recommendations.

We shall bring up for consideration various aspects of this problem under six general headings:

## I. Case Finding

- II. Control and Treatment
- III. The Economic Factors Involved
- IV. Coöperation of the Departments of Health
- V. Education: Lay and Professional
- VI. Administration

## I. Case Finding

Let us first compliment ourselves upon the fact that this survey has proven that the early detection of syphilis in this community is approximately twice as great as in other communities, and that we have, as Dr. Aselmyer has so well expressed the situation, "A high index of suspicion." It may be well pointed out that many of the cases seen in the later manifestations were undiagnosed elsewhere or were self-treated in their early stages. From this latter viewpoint we must consider the educational factor. We have, however, failed to discover sources or contacts to any appreciable degree, though we do recognize, as is demonstrated by our previous survey, that every infected case represents another so infected. In this connection, as will be pointed out subsequently, a specially trained worker in this field, operating from the individual physician's offices, would be of inestimable value.

## II. Control of the Patient

In nine out of ten cases the economic factor enters the picture to a more or less overwhelming degree. Patients are lost or disappear solely because of this economic factor.

These venereal patients may be divided roughly into three groups<sup>4</sup>; first, a small proportion who are so emotionally prostrated by the infection that they will adhere strictly to advice and follow all treatment rules to the letter. Second, and by far the



greatest group, those individuals who are "open to conviction" and may be influenced by understanding discussion to carry their treatment through to completion. Third, another small group who are utterly indifferent to their own personal outcome and equally so of the consequences to those with whom they come in contact. Considering the second group, the care and time to be spent at the first visit, which is truly so many times neglected, is worthy of emphasis. The availability of a social contact worker, already mentioned, will also be of great assistance in control of both of the latter two groups. The unreported patient who disappears is a lost patient, as well as a public menace. It was found in the survey conducted early in 1937 that many physicians did not wish to so report. We must recognize that the failure of physicians in Ingham County to completely report these cases has hampered and will hamper a successful control program. These two surveys have been completed for the purpose of forming a base line in establishing a true control program. The incidence of cases treated and those reported shows a marked discrepancy in that just completed, as well as that conducted previously. Unless a true analysis is available, funds, which it is proposed shall be allocated for the remuneration of the individual physician for the treatment of patients in the low economic bracket, will be grossly inadequate. Cases will be lost and our obligation to the community will remain only partially fulfilled.

### III. Economic Factors

In the report just submitted by the United States Public Health Service it was pointed out that nine out of ten luetics could not afford minimum standard treatment. The income base which was chosen in estimating the above ratio was three thousand dollars per year. It is the sense of this committee that that base line has been placed considerably too high and this committee wishes to point out that 43 per cent of the physicians in the state of Michigan were found to have an annual income of less than twenty-five hundred dollars per year.<sup>5</sup> It is certainly true, however, that a very large proportion, which might reach 75 per cent, cannot stand the financial drain of continued regular treatment without assistance.

It is manifestly important that funds be

made available for the operation of any program for the control of communicable disease, but even more particularly so when one considers the fact that the peak of these infections is reached at the age of twenty-five years, at which time few individuals are self-sustaining to a degree sufficient to stand the strain of anti-luetic treatment. It is the province of your committee to maintain this group of individuals under treatment by the individual physician, but it is a fundamental necessity that the physician should be remunerated for such treatment from the viewpoint of the patient, the common good, and that of the physician. It is true that the economic burden upon the physician and patient has been lessened to some degree by the state with the rendering available free therapeutic agents for such patients as are in economic stringency. Nevertheless, it is equally true that it appears advisable for the individual physician to be reimbursed from public funds according to a minimum fee schedule for such treatment. In many cases it may well be possible for the patient to make some payment, to which might be added a balance from public funds to compensate the physician up to such minimum fee schedule. Such recommended minimum fees would be understood to apply only to those in the lower economic group. Therefore, we feel that the treatment of venereal disease should and can be maintained under the guidance of the individual practicing physician as advocated by the President of the Michigan State Medical Society and the Committee on Syphilis Control, and that the local clinic should care for only those patients who could not be or would not be cared for by private physicians. It is noteworthy that Donald Gudakunst,<sup>2</sup> Commissioner of Health of the State of Michigan, stated:

"It is our contention that the treatment of syphilis rightly belongs in the hands of the private physician, for it is here that the maximum benefit will be obtained from treatment. It therefore becomes a problem of the Health Department to provide ways and means of giving treatment to those who are unable to finance their own care. . . . The clinics are necessary and do fulfill a definite function of completing the job of supplying treatment to all persons, but they should not be pushed to the foreground as the most desirable method of administering skilled care. The cost of treatment is relatively expensive. Therefore, the state should be able to assure every afflicted person of an adequate amount of care. This in many instances will mean the payment of the physician by the state for services rendered in his own office to indigents."

The contrary view is expressed by R. H. Riley,<sup>6</sup> Director of Health of the state of Maryland. This was pointed out by the president of the Michigan State Medical Society<sup>1</sup> in his letter of April 23 to all members of the Society. Riley states, "More than a year ago the State Department of Health operated a total of thirty-five clinics, all of which were free for the treatment of syphilis. Every county of the state was provided with at least one; seven counties had more." It appears that we have been blessed with a far-seeing Commissioner of Health.

#### IV. Coöperation of the Departments of Health

A. It is further axiomatic that any such program must have some point of centralization and general administration, and that, by law, it shall be placed in the hands of the City Health Director as it would pertain to the city of Lansing, and the health officer of the new county health unit as it might pertain to the remainder of Ingham County. However, the successful administration of any such program must rest upon the integral coöperation of the members of the profession under this jurisdiction and will depend upon the individual physician, reporting all cases of communicable disease, including those of genito-infectious origin. It should further include the reporting of cases lapsed from treatment in order that they may be returned to treatment, and lastly, it should include the reporting of all cases discharged as cured. Without this simple array of data, as previously pointed out, our future program will be crippled, sources of infection will remain unknown, and any allotment of funds would be made upon an inadequate basis. In addition, further factual data, which it is hoped to compile, would be erroneous. We have seen that we have been at least 40 per cent negligent in our reports in the past.

B. It is recommended that the Departments of Health maintain an active file of infected cases under treatment and that this file be of an elastic nature, permitting the recording of patients transferred from one physician to another or those who have lapsed from treatment, in order that the number of known infected individuals not under treatment may be minimized and that the coöperation of the individual physician

from the viewpoint of reporting such cases as previously mentioned be obtained to a greater degree.

C. In view of the overcrowded situation at the local clinic and in view of the fact that these cases present an even greater problem than that of the private patient,<sup>3</sup> it is urged that facilities at this clinic be improved and that this question be referred to a special committee for study. Such committee should include the city physician and representatives from the Board of Health and the Public Health Committee of the Ingham County Medical Society. Also, in consideration of the fact that special equipment, knowledge, and ability are required for the recognition of the early manifestations of late syphilis, expert consultation should be made available as may be necessary from the viewpoint more particularly of cardiovascular, central nervous system, and visceral syphilis. These consultants should be remunerated at a minimum rate of from three to five dollars per case.

D. That the Department of Health obtain such necessary equipment<sup>7</sup> for tabulating and recording these cases for statistical material maintained by the United States Public Health Service in order that the results and progress of this control program may be evaluated in the future.

E. It is to be further recommended that a specially trained contact individual be added to the personnel of the departments of health for both the city and county. It has been pointed out that, "The employment of a confidential persuasive approach to elicit a voluntary response from the patient, in the hands of a trained individual, is about half again as productive of epidemiologic information as is the untrained coercive approach." This from Norman R. Ingraham, Jr.,<sup>3</sup> quoted in *Venereal Disease Information*, March, 1938. Such a trained worker should operate from the individual physician's office with the close coöperation of each physician. It is worthy of emphasis that the physician who in the past has been afraid of losing his patient has already lost the one who does not return, and, further, has possibly liberated upon the community an actively infected case without thought of possible consequences. In the experience of one of us, simple contact letters from the department of health to the patient, reported



as delinquent, returned fourteen of sixteen cases so reported to this physician for continued treatment.

#### V. Education—Lay

A. This matter has already been under way and has continued through national organizations, the United States Public Health Service, State Medical Society, the State of Michigan, and by our own County Society, through the medium of published articles, advertisements, lectures, and radio broadcasts. Much has been accomplished from this point of view. We are, in this community, carrying our efforts further by reaching individuals of the adolescent age in both of our city high schools, and it is noteworthy that an increasing number of patients suffering from either syphilis or gonorrhea are consulting the State Department of Health and our local health department for advice and recommendations as to treatment.

It is urged that these educational programs be continued and enlarged and that all members of this society be requested to accept invitations or suggest speakers for the presentation of the problem of genito-infectious diseases to lay groups of any type. However, said members to do so only after consultation with, and with the advice of, the to be proposed Sub-committee of Venereal Disease Control. This latter suggestion is made in view of the fact that our efforts have not been in the past standardized and unfortunately there have occurred some misquotations upon the part of individual speakers. It must appear desirable to all that no contradictory statements be made.

B. It is of prime importance that the closest coöperation be sought with the pharmaceutical profession in an effort to eliminate counter prescribing and self-treatment by the patient, which so often only masks an active or latent infection and leads to ultimate disastrous results. This fact alone unquestionably explains many luetics undiagnosed until tertiary manifestations have become evident. It is suggested for consideration that all druggists in this community be mailed copies of such resolutions as may be ultimately adopted by this society.

#### Education—Professional

A. It is to be reiterated that emphasis be placed upon the importance of the first visit

to the physician and it is urged that more considerable time and care be spent at this time. We are all contributing much, as has already been pointed out, to the control of the patient, but it is further important that we coöperate individually in sending adequate reports to our respective health departments.

B. It is desirable for the purpose of further study, as well as the discovering of additional unknown luetics, that the program of the sero-diagnostic method employed during the recent survey be continued within the capacity and ability of the physician to do so, and, as a corollary to this, that routine sero-diagnosis be carried out upon all pregnant women. In fact, this should be regarded as of equal importance with progress urinalyses and blood pressures in such cases. During the two months immediately preceding the 60-day survey period, 1,770 sera were submitted; during this survey 7,600; and in the next 60-day period 3,141, an increase of 1,371 over the interval prior to the survey.

C. It is suggested that the Ingham County Medical Society during the ensuing year inaugurate a two-day clinic for instruction of its own members as well as others who might wish to attend, as to the minimum standards of treatment, epidemiology, complications, reactions, et cetera, for the purpose of increasing our own knowledge and improving our technic in these matters, such clinics to be entirely separate from the annual clinic and repeated if and when deemed advisable. The facilities for such postgraduate courses will be greatly increased in view of the recently established County Health Unit. Doctor Gudakunst has suggested that there could be transported from Detroit typical clinical material for use in such clinics. We must appreciate that two out of three of our early diagnosed cases, of which we might boast, have received grossly inadequate treatment from the viewpoint of protecting against infectiousness and that only one in five has been protected against ultimate disastrous results. It is to be recommended that the standard of treatment of the Committee on Syphilis Control of the Michigan State Medical Society be accepted within this community and that each physician familiarize himself with this minimum standard treatment.



It is to be recognized that serologic reports should not be used as criteria of cure, but rather the courses of treatment received.

## VI. Administration

As previously mentioned, the direct administration must of necessity rest in the hands of the Departments of Health, with the coöperation and guidance of the Ingham County Medical Society. It is suggested that the name of the Public Health Committee be changed to that of the Preventive Medicine Committee, which is in harmony with the similar committee of the Michigan State Medical Society. It is also recommended that a sub-committee of the proposed Preventive Medicine Committee be established as a permanent committee; namely, a Venereal Disease Control Committee, this committee to work in close harmony with the departments of health of the city and county on these matters and to maintain the care of the syphilitic and gonorrheic patient by the individual physician; to furnish aid and assistance to such physicians; to manage and direct a proposed postgraduate clinic if endorsed by the society; to follow and report all progress, to handle, supervise, and edit all publicity. It should be the duty of such committee to work with the physicians in the interest of the public and to maintain as far as possible the status of the family physician and the individual patient. In view of the fact that an increasing number of individuals are consulting various health agencies for advice as to treatment of these infections, names of physicians attending a proposed clinic should be placed upon lists with these health agencies for reference of such patients.

It is worth reiterating that successful administration of any program must rest upon the integral coöperation of members of this society.

In closing, it is recognized that, while we have excelled in diagnosis, we have been remiss in treatment and that, in addition, treatment must be two-fold: first, to render the infected individual non-infectious to others, and secondly, to protect him from ultimate disastrous results of infection, thus minimizing the incidence of public charges and ultimate expense to the community as a whole, as well as ourselves.

The possibility of securing a contact worker through Social Security funds is very considerable, as is that of remuneration, as

suggested, of the individual physician for the patient in the lower income bracket. It is our aim in this effort that as many patients as possible be offered treatment at the hands of the individual physician in contradistinction to that of a clinic. It is worthy of emphasis that the program suggested for establishment of such a two-day postgraduate clinic, both didactic and clinical, is in harmony with the principle of the Society for improving the standards of the practice of medicine within this community and our efforts in this behalf must be regarded as sincere by local governing bodies.

The following program of control is therefore submitted:

1. That a sub-committee of the Preventive Medicine Committee be appointed to be known as the Venereal Disease Control Committee, such committee to be a standing committee of the Society, appointed by the president.

2. That the function of this committee be as already described in the preceding report.

3. That it is the sense of the Ingham County Medical Society that treatment of venereal disease be maintained under the guidance of the individual private physician and that the clinic treat only such cases as cannot be so handled.

4. That it be recommended that venereal disease contact workers be added to the Lansing and County Departments of Health and that it be desirable that such individual receive his training in a special course given by an accredited authority.

5. (a) That in addition to free drugs, certain public funds or public monies be made available for minimum remuneration of the physician in the treatment of these cases. That the patient should pay within his capacity and the deficit between such minimum fees be made from public funds mentioned. That such minimum fees be agreed upon among the members of the Ingham County Medical Society as two dollars for intramuscular therapy and three dollars for intravenous. (b) In uncomplicated gonorrheic cases the minimum fee be one dollar.

6. That improved facilities be made available for the City Clinic for the treatment of completely indigent patients.

7. That competent consultation for complications be made available at a rate of remuneration of from three to five dollars per case.



8. That educational programs of lay groups be continued and increased under the guidance of the Sub-committee on Venereal Disease Control.

9. That the Ingham County Medical Society during the ensuing year inaugurate a two-day postgraduate clinic in venereal disease.

10. That such individuals as may consult public health agencies relative to receiving treatment be referred to physicians taking advantage of post-graduate educational opportunities.

11. That the departments of health of Lansing and Ingham counties purchase and maintain an active file for control of infected cases and in addition that these departments of health obtain such necessary standard equipment as is advocated and approved by the United States Public Health Service.

12. That sero-diagnostic testing of patients be continued within the capacity and ability of the physician to do so.

13. That routine sero-diagnosis be carried out on all pregnant women.

14. That the essence of this report be mailed to all druggists in Ingham County requesting their coöperation in the eradication of counter-prescribing and self-treatment.

15. That each individual physician report all cases of genito-infectious disease at the time of diagnosis; when treatment has lapsed; and at the time of cure.

16. That the standard treatment ap-

proved and adopted by the State Committee on Syphilis Control be accepted within this community.

17. That copies of these recommendations as may be pertinent to the Department of Health be forwarded to the officers of the Department of Health, to the Board of Health, members of the City Council, the Board of Supervisors of Ingham County, and the mayor of the city of Lansing.

18. That the Sub-committee on Venereal Disease Control make such arrangements with public officers as may be possible for the remuneration to the individual physician for the treatment of venereal disease cases in the low-income bracket.

\* \* \*

These recommendations were adopted at a special meeting of the Ingham County Medical Society on May 24, 1938.

PREVENTIVE MEDICINE AND PUBLIC HEALTH COMMITTEE, INGHAM COUNTY MEDICAL SOCIETY: O. H. Bruegel, Chairman, R. S. Breakey, C. Bradford, Frank Stiles, George Stucky, John Wellman, Harold Wiley, E. R. Van der Slice.

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### DISCUSSION OF PAPERS BY DR. A. J. ASELMAYER AND LIDA J. USILTON, DR. HARTHER L. KEIM AND DR. R. S. BREAKEY

DR. HENRY COOK: I wish to congratulate the Ingham County Medical Society upon its efforts in this one field of preventive medicine. I think that all of us who are connected with organized medicine realize the interest that is certain in our group and also somewhat of the reactions that take place in the minds of other men who are not quite so active in the field of preventive medicine. Sometimes these discussions become rather irksome and we sometimes ask the question, "What is it all about, and where are we going?" Personally, I feel that we are, as a profession, more or less upon the spot to take an interest. There never was a time when the public was demanding so much of the medical profession in their health problems as they are today, and I feel that the efforts which we put forth are going to mold more or less the future course of the practice of medicine. I believe that the example which you have set for the profession in other parts of the state stands out above any other effort of any other society, especially in syphilis. Other counties are taking up the problem of syphilis as the result of the work which you are doing and the work done

by the Preventive Medicine Committee of the State Medical Society. We shouldn't feel that syphilis is the last thing we are going to tackle. I believe it is our job to keep in step with other organizations such as the United States Public Health Service. We should support its activities in this field of public health medicine for two reasons. In the first place, it will help to make their efforts much more successful and certainly it will place our profession squarely before the public as a group of public servants willing to meet the responsibility. There have been many difficulties and many misunderstandings in the past upon the parts of both the public officials and the profession in understanding the relationships with each other. We are fortunate today to have a State Health Commissioner who wishes to carry our work on a strictly ethical basis. With the enthusiasm as evidenced by your County Society, I hope for a good future for the practice of medicine in this state if we meet our responsibility, which I have every confidence we will do.



## DISCUSSION

DR. LOREN SHAFFER, chairman of the State Committee on Syphilis Control:

As chairman of the State Committee on Syphilis Control, I can say that we of the committee are here to learn of the things you have done. If our program is to succeed it will be necessary to have just such leadership as you have developed in setting up a program. There are many things that will be necessary to keep the control of syphilis and venereal disease in the hands of the physicians, where it belongs. It is this type of effort which will do it. I think we in Michigan are in an unusual position as far as being able to set an example to the rest of the country in control of preventable diseases, including syphilis, through the practicing physician instead of clinics and health departments. I am sure our Health Commissioner will approve and express much better than I am able to, that same idea. The problem of syphilis control, however, is not necessarily an easy one. It isn't over by the excellent work you have already done. You have made the start; I hope that you'll be able to continue it. You have found your basis, which is the first step in any syphilis control program. The next step is to arrange adequate treatment for those cases, and there again we will sit, possibly at your feet, and watch your future developments in this field. There can be many things said on this particular phase. I think you are going to hear enough about syphilis later tonight. However, Doctor Parran has summarized the whole problem of syphilis control roughly into two parts: finding and treating these patients. Unfortunately, such a survey such as you have carried out will fail of finding those cases of syphilis that are necessary to find, to control this disease, and those are the cases of early syphilis. It is estimated, and I think the estimate is high, that only half of our cases of early syphilis ever report to a physician for diagnosis or treatment in the early stage, when they are infectious and treatment is urgently indicated. Looking over our own statistics in a large group of cases, I was surprised to find that out of 6,000 cases of syphilis only from 100 to 200 of those cases were diagnosed as early syphilis. What happens to these cases? Why don't they reach the doctor? This is principally due to the paucity of early symptoms; the weakness of drug store prescribing, et cetera; the lack of education of the laity; failure on our part in searching for sources and contacts of those early cases that do reach our office for diagnosis. We'll hear more tonight about treatment of early syphilis, which is such an important part of our program. It is conservatively estimated that only 20 per cent of our early cases of syphilis which report to our offices ever take such treatment to secure an arrest of the disease or to control infectiousness. It is a big problem in syphilis control when only one-half of early cases are diagnosed, and less than one-fifth of one-half that are diagnosed receive adequate treatment. Let's carry on our program even further. Prevention of congenital syphilis should be a rather easy problem if we can utilize the blood test in pregnancy. I wish to compliment you for the outstanding work you are doing in syphilis control and the example you are setting.

\* \* \*

DR. DONALD GUDAKUNST, Commissioner of Health for Michigan: The control of syphilis, while it is a tremendously important public health problem, is not a problem that can be handled by the Health Department or by the Public Health Departments. It is a thing which must be handled and controlled by the public itself. It must be treated and handled as other diseases are handled. In fact, this County Medical Society has undertaken the first major step,

the interest of the public and interest of the physician in this disease means that we have the battle at least nine-tenths won. The rest of it is going to be comparatively easy. When we can get the medical profession working on it and the public interest in it, then your Public Health Department has little else to do with it save a little help here and there.

\* \* \*

DR. GEORGE H. BELOTE, Associate Professor of Dermatology, University of Michigan: I'm truly very sorry that I had not had this material for study. I came for what I could learn. I wanted to come to learn what was going on and if the material would be applicable to other communities and what could be done about it. Doctor Aselmyer has presented a large amount of material. It would be perfectly foolish for me to attempt to draw conclusions from what I have been able to gather. If I did not misinterpret, I find that your percentage of positive tests as determined by routine testing is somewhat less than we find in routine serologic tests at the University Hospital. The routine blood test has been part of the examination of every patient registering at the University Hospital for years and we find in that group which represents a little different group than you are accustomed to deal with in your private offices, this group might be comparable to the lower two-thirds of the patients that you deal with in your private offices, we find that if we consider both weakly and strongly positive tests we have 5 per cent of positives. Here you have 2.4 per cent. If we consider only the strongly positive tests we find approximately 4 per cent of routine positives. I do not think the question of false positives and false negatives is of great importance although we do realize that there are considerable numbers of both. We're finding more and more that certain conditions, particularly with increased sensitivity of serologic tests, are giving us false positives. Serologic tests which are positive at the present time would show, if they were taken with the sensitivity of the test of twenty years ago, perhaps 65 per cent less positives.

One point would deserve a little more study. Doctor Aselmyer pointed out that approximately 237 more positives were found in the survey period than had been found in a like period before. I would like to know which were actually actively infectious dangerous cases and how many were among pregnant women. If they were actually actively infectious cases this would be of great importance because those cases are the ones which we expect to disseminate infection. I want to go further into the question of inadequate treatment. When you give inadequate treatment for any reason whether through your own failure or through the fault of the patient, you have not only failed to protect the patient and contacts, you have actually made that patient worse than he otherwise would be. Studies have shown that the ultimate outcome in cases inadequately treated ultimately are worse than those left alone. It does not take into consideration one fact which may be important from the standpoint of contacts. Even with inadequate treatment you may protect a certain number of contacts for a certain period of time and from that standpoint any treatment is important. On the other hand, I repeat, statistics and studies have shown that the patient actually ultimately is worse off than had he been left entirely alone and without treatment.

There are a great many other points that could be taken up here. I think it is of a good deal of importance and feel that the Society is to be congratulated and hope that the study may be carried on.



## A SURVEY OF SYPHILIS IN OAKLAND COUNTY FOR 1937\*

The Committee on Syphilis of the Oakland County Medical Society

HAROLD R. ROEHM, M.D., Chairman; P. V. WAGLEY, M.D.;

JOHN D. MONROE, M.D., and E. E. HAMMONDS, M.D.

A survey of syphilis in Oakland County has been undertaken and completed by the Committee on Syphilis of the Oakland County Medical Society, at the direction and expense of the Society.

The method of assembling the data was as follows: A questionnaire patterned after that used by the Venereal Disease Division of the United States Public Health Service was prepared and mailed to every Doctor of Medicine, osteopath, and chiropractor in practice in Oakland County. The questionnaire requested the following information: The age, sex, color, clinical diagnosis, blood test and treatment in every case of syphilis treated by the physician in the year 1937. Each physician who failed to reply was re-circularized, and those who then failed to reply were telephoned.

There are at the time of writing 157 doctors of medicine, twenty-five osteopaths and eighteen chiropractors in active practice in Oakland County. Reports have not been received from five of these, so that this report is based on the replies from 195, or 97.5 per cent, of the physicians in the county.

Of the 152 doctors of medicine who returned a report, eighty-five (55.19 per cent) have one or more cases of syphilis under treatment; five (20 per cent) of the osteopaths have one or more cases under treatment; and no cases are being treated by chiropractors.

Treatment of syphilis in the county is obtainable from two sources, the private physician and the Oakland County Health Department. In 1937, 409 cases of syphilis were treated by private physicians, and 292 by the County Health Department. Twenty-one patients were seen but refused treatment, making a total of 722 known cases of syphilis in Oakland County. Of these patients 692 were receiving treatment, 43.36 per cent from the County Health Department, and 56.64 per cent from private physicians in 1937. Of these cases, thirteen patients also had gonorrhea. Four hundred and fifty-five of the 722 cases (61.49 per cent) were first reported in 1937. If the population of the county is conservatively estimated at 250,000, and if the lowest average figure of incidence of syphilis in industrial populations found by surveys elsewhere, or 4 per cent, is allowed, we would

expect to find in Oakland County approximately 10,000 cases. As we have found only 722 known cases, of which 692 were under treatment in 1937; it would appear that over 90 per cent of the expected syphilitic population of the county either has not been diagnosed or has been diagnosed and is not receiving treatment, or both.

The 722 known syphilitic patients were classified as follows:

Prenatal .....	16	2.22%
Early .....	144	19.94%
Latent .....	370	51.11%
Late .....	165	22.86%
Congenital .....	27	3.74%
	<hr/> 722	<hr/> 99.87%

The prenatal cases are defined here as pregnant women, the early cases those of primary and secondary syphilis, and among these are reported three cases of chancre with dark field examinations. The latent cases are asymptomatic, the congenital cases are defined as those which are the result of intra-uterine infection with snuffles, rhagades, desquamation, Hutchinsonian teeth, corneal ulcers, saddle noses, joint effusions and other stigmata of so-called congenital lues. The late cases include asymptomatic neurosyphilis, periostitis, gumma, taboparesis, general paralysis, central nervous system lues, and cardiovascular syphilis.

Of the 722 cases, 109 (15.09 per cent) were negroes, and 613 (84.91 per cent) white. 349 were females and 373 males.

The average age of acquiring syphilis as determined by averaging the early cases was 27+ years.

The treatment that these syphilitic patients are receiving has been found by the committee to be adequate in the majority of the cases except in duration. The county is

\*Read at the meeting of the Oakland County Medical Society, April 13, 1938.

limited in its treatment of syphilis of the central nervous system by lack of equipment and personnel for fever therapy. The only such treatment available is the malarial therapy at the Pontiac State Hospital, where the work is handicapped by the over-crowded condition of the hospital and limited to state patients.

Treatment is not being given to twenty-one known syphilitic patients. Since these patients are not in an infectious stage of the disease, they cannot be quarantined or followed up, as there is no legal provision for such procedures. As long as a syphilitic is not infectious, there is at present no method by which treatment can be forced on such a patient.

Free drugs for treatment of syphilis are now available at the City and County Health Departments for the treatment of individuals unable to pay for such drugs.

### Summary

At the time of this survey there were seven hundred and twenty-two known cases of syphilis in various stages in Oakland County.

Four hundred and nine of these are under treatment by private physicians, and 292 by the County Health Department. Twenty-one cases refused treatment.

The treatment these cases are receiving appears adequate for the most part except for the treatment of syphilis of the central nervous system.

### Conclusions

1. Approximately 90 per cent of the cases of syphilis of all types in this county are not being diagnosed or treated if the lowest average per cent of incidence of syphilis for an industrial population is accepted as reasonable for Oakland County.

2. The reports of only sixteen cases of prenatal syphilis indicate that not enough blood tests have been done on pregnant women. A survey of the American Social Hygiene Association in coöperation with the U. S. Public Health Service in 1935 showed that approximately 3 per cent of all women of child-bearing age are syphilitic.

3. It follows that the report of twenty-seven cases of congenital syphilis indicates that an insufficient number of blood tests is being done with this diagnosis in mind. A coöperative clinical group in 1934 found in

a study of 431 patients that only 57 per cent of the infants born of syphilitic women with positive Wassermann reactions escaped syphilis as compared with 81 per cent of infants born of syphilitic mothers with negative Wassermann reactions.

4. The treatment of syphilis in Oakland County is adequate as far as it goes, and the doctors of medicine treating syphilis appear to be well informed. There is, however, scant provision for the treatment of central nervous system syphilis.

5. With the present statistical setup in the county it is impossible to give with any absolute accuracy the actual number of cases of syphilis present, the incidence of syphilis, in any one year, and the final results either with or without treatment.

6. The recent public educational campaign has brought out many old cases of syphilis for treatment, and the continuance of this campaign will bring out more.

7. There is a necessity for a comprehensive review of the diagnosis of syphilis in all its stages to be presented to the physicians of the county so that the presence of syphilis may be suspected in any patient presenting himself for treatment of any complaint whatever.

8. In the face of the low apparent incidence of syphilis as shown by the reports of only seven hundred and one cases under treatment in 1937, it is obvious that blood tests should be done on more patients than are done at the present time.

9. Case finding, adequate treatment and follow-up, and the prevention of new cases, through prenatal examination and registration of cases coming in from outside the county are the prime requisites in the control and eradication of syphilis.

### Recommendations of Committee

1. The diagnosis of syphilis cannot be made on one positive blood test in the absence of clinical evidence. Repeated tests should be made preferably by separate laboratories at the present time.

2. The Society should support any legislation leading to the testing for syphilis of all pregnant women.

3. The Syphilis Committee of the County Medical Society should be made a standing committee with the following purposes.

a. The approval for release of all edu-



cational material in the public campaign to control syphilis.

- b. The selection for and determination of special treatment for refractive indigent cases of syphilis which fail to respond to routine treatment.
- c. An annual survey of the county to determine morbidity of syphilis and the efficacy of the existing methods of treatment.

4. The standing Syphilis Committee should contain among its members the Chief of Staff of the Pontiac State Hospital, the health commissioner of the county and of the city of Pontiac, and members of the County Medical Society familiar with and interested in the diagnosis and treatment of syphilis.

5. The Society should support any movement which would result in finding any cases of syphilis among

Public and private transportation employees  
Municipal employees  
Domestic servants  
All food handlers  
Hotel and restaurant employees  
Barber and beauty parlor employees  
Staffs of all general and special hospitals  
Patients attending all public dispensaries and clinics  
Applicants for children's boarding home licenses  
All children adopted from orphanages  
All industrial employees

6. The Society should support any legislation to the end that a legal control be given enabling adequate following up of cases until sufficient treatment has been given.

7. Since there will probably be available county, state or federal funds to recompense physicians who are interested in the treatment of indigent syphilitics, such physicians should indicate their qualifications to the committee and be listed so as to be available.

8. A carefully planned continuous program of public information and education participated in by all community agencies should be arranged in conjunction with the State Medical Society.

9. Physicians should accept the treatment of syphilis as their duty and charge

according to the patients' means, since free drugs are now available.

10. Since education and industrial pressure, the marriage law and free drugs are bringing out many formerly untreated cases for treatment, and since at present our facilities are limited, legislation to force compulsory blood testing in general at this time may not be advisable or necessary.

11. This Society should continue to see that its membership is adequately informed as to the diagnosis and treatment of syphilis in all its stages, so that the members may competently discharge their duties as guardians of the public health.

12. Since there are at present no facilities for fever therapy of C.N.S. syphilis in the county except for malaria treatment at the State Hospital, where the facilities are limited, it seems advisable to recommend the installation of such equipment in our hospitals and the training of the personnel necessary to use such methods.

13. It is suggested that an index system be installed by the County Board of Health in conjunction with the State Board of Health to build up an accurate morbidity and treatment register free from duplicates.

14. The Society should support industry in the blood testing of all workers so that such workers may themselves benefit by treatment in their general welfare, as well as in the reduced hazard of industrial accidents.

15. It is extremely important that employers be advised that syphilis in an employee is not a cause for his discharge from employment, provided he is receiving adequate treatment. The employee must understand that he can receive adequate treatment and continue his regular work without hindrance, but, if untreated, he will sooner or later become incompetent.

16. The committee recommends that a centralized, dependable serological laboratory be established by the county, where the most modern serological methods of diagnosis now in use will be available under the direction of a competent serologist.

17. Since there are apparently about nine thousand syphilitics undiagnosed or diagnosed and untreated, or both, in Oakland County, physicians are strongly urged to take routine blood tests for syphilis on all patients.

# SIX MONTHS OF OCCUPATIONAL DISEASE REPORTING

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LANSING, MICHIGAN

The Occupational Disease Reporting Law (Act 210, P.A., 1937) is now six months old. During those six months, reporting has started and the initial data are now available for tabulation. Of all the reports, 56.5 per cent came from Detroit, due probably to the special efforts of the Wayne County Medical Society and the Detroit Dermatological Society to have their members well acquainted with the act and to report all cases. Occupational disease report forms were sent to approximately 5,400 physicians, yet reports have been received from only 114 or approximately two per cent. This indicates that efforts to discover or report occupational diseases are not being made by a large number of the profession. It is recognized, of course, that many physicians will never see an occupational disease case, but experience of other states would indicate that reports should come from more than five per cent of the physicians in the state.

Table I indicates the geographical distribution of the reports received and the number of physicians in those counties who have made the reports. It will be noted that no reports have been received from such industrial counties as Bay, Gratiot, Macomb, Midland, Monroe, and St. Joseph, and that in many of the other so-called industrial counties only one or two reports have been received. Where more than just a few reports have come in, it is due entirely to the reporting of a large number of cases from plants employing a full-time plant physician. Most of the reports in Genesee, Kent and Saginaw Counties come from one or two industrial plants maintaining a medical department. In Detroit this is true to a somewhat lesser degree.

Table II shows the distribution of cases according to diagnosis. It is quite evident from this table that physicians are being guided largely by the schedule of diseases made compensable by Act 61, P.A. 1937. Only three causes of occupational disease not specified in the schedule of the Workmen's Compensation Law have been reported. Dermatitis constitutes the largest single cause, 28.7 per cent of all cases. Experience of other states, where reporting has been required for some time, indicates that about 66 per cent of all reported cases are dermatitis.

Table III indicates the causative agent for the cases of dermatitis which have been reported.

TABLE I. DISTRIBUTION OF OCCUPATIONAL DISEASES BY COUNTIES AND THE NUMBER OF PHYSICIANS REPORTING IN THE COUNTIES

County	Total Cases Reported	No. of Physicians Reporting
Allegan .....	1	1
Berrien .....	1	1
Calhoun .....	5	3
Cheboygan .....	1	1
Dickinson .....	4	2
Genesee .....	22	5
Ingham .....	1	1
Iron .....	1	1
Isabella .....	1	1
Jackson .....	1	1
Kalamazoo .....	2	2
Kent .....	31	9
Lapeer .....	2	1
Lenawee .....	5	3
Manistee .....	1	1
Marquette .....	1	1
Montcalm .....	1	1
Muskegon .....	8	5
Oakland .....	11	3
Ottawa .....	1	1
Saginaw .....	29	6
Shiawassee .....	3	2
St. Clair .....	10	2
Van Buren .....	3	2
Washtenaw .....	1	1
Wayne		
(exclusive of Detroit)....	48	15
Detroit .....	268	42
Total—26 counties.....	463	114

The number of cases of lead poisoning appears unusual, but further analysis of these reports shows that practically all cases were reported from one source.

Hernia apparently presents a problem to plant physicians, inasmuch as it is compensable both as an accident and as an occupational injury. Many of the cases have been "discovered" through introduction of periodic and pre-employment examinations. As time goes on this item should show a material decrease. Similarly, the items for silicosis and pneumoconiosis should decline



## OCCUPATIONAL DISEASE REPORTING—HEPLER

TABLE II. DISTRIBUTION OF REPORTED OCCUPATIONAL DISEASES BY CAUSES

(Number in parenthesis is item number in schedule of Compensation Act)

County	( 2) Lead	(12) Dope	(13) Formaldehyde	(14) Chrome	(18) Miner's Diseases	(22) Carbon Monoxide	(24) Petroleum Products	(25) Blisters & Abrasions	(26) Bursitis & Synovitis	(27) Dermatitis	(28) Hernia	(29) Phthisis	(30) Silicosis	(31) Pneumoconiosis	Myositis	Paronychia
Allegan			1													
Berrien													1			
Calhoun										4			1			
Cheboygan				1												
Dickinson													4			
Genesee	1							1	1	19						
Ingham							1									
Iron										1						
Isabella										1						
Jackson										1						
Kalamazoo						1								1		
Kent	1							12		10	1		3	4		
Lapeer										2						
Lenawee						1				4						
Manistee										1						
Marquette													1			
Montcalm										1						
Muskegon								1		2			5			
Oakland	1								5	3	1		1			
Ottawa										1						
Saginaw				1	1			13	4	9				1		
Shiawassee										2	1					
St. Clair										1			9			
Van Buren						1				1				1		
Washtenaw										1						
Wayne	1			1		2			1	11	8		18	6		
Detroit	68	1				4		1	15	59	42	3	59	8	7	1
Total	72	1	1	3	1	9	1	28	26	134	53	3	102	21	7	1

after all the cases, found for the first time with the introduction of employment examinations, have been reported.

Among the reports received, a certain number failed to fall in the schedule classification, and, from either lack of information or from the information given in the report, were not considered as true occupational disease reports. Table IV lists this group according to the physician's diagnosis.

The one item over which the most discussion has occurred is friction burns.

Some physicians claim that the burn is due to constant friction over a period of time. Some feel that it must be reported because in the schedule of compensable diseases it is made compensable under item 25: "Disability arising from blisters or abrasions, caused by any process involving continuous friction, rubbing or vibration causing blisters or abrasions."

Regardless of what arguments may be raised, the act provides that occupational diseases shall be reported to the Commis-

# OCCUPATIONAL DISEASE REPORTING—HEPLER

TABLE III. OCCUPATION OR CAUSATIVE AGENT  
OF REPORTED CASES OF DERMATITIS

Acid .....	3
Bakers and confectioners.....	4
Brass .....	1
Buffing .....	1
Chemicals specified .....	6
Cement .....	1
Degreasing .....	1
Dyes and dyed goods.....	6
Foodstuff .....	3
Ink .....	3
Leather .....	1
Metal .....	12
Oil, grease, cutting compounds.....	56
Paint, lacquer, enamel, varnish, thinner..	5
Petroleum products .....	4
Plating .....	2
Rubber compounds .....	2
Soap and cleaning compounds.....	14
Soy bean .....	1
Sugar making .....	1
Welding .....	1
Wood .....	6

TABLE IV. OCCUPATIONAL DISEASE REPORTS  
WHICH FOR SOME REASON GIVEN ON RE-  
PORT OR FOR LACK OF INFORMATION  
WERE NOT ACCEPTED AS BEING TRUE

## OCCUPATIONAL DISEASE REPORTS

Arthritis .....	1
Boils .....	2
Bronchitis .....	1
Burns, chemical.....	7
Burns, friction .....	32
Burns, oil, infected.....	1
Callus .....	1
Fracture .....	1
Furuncle .....	4
Herpes zoster .....	1
Hernia .....	3
Inflammation and infection.....	4
Influenza .....	1
Laceration .....	1
Lumbago and lumbosacral strain.....	4
Methane poisoning .....	1
Myalgia .....	1
Neuritis, ulnar .....	2
Pain .....	1
Poison ivy.....	1
Pustule .....	1
Sacro-iliac strain.....	6
Sinus .....	1
Sprain and strain.....	6
Soreness .....	1
Syphilis .....	1
Tender thumb .....	1
Tuberculosis .....	3

sioner of Health, and further specifies that:

"An occupational disease, for the purpose of this statute, is an illness of the body which has the following characteristics:

- "1. It arises out of and in the course of the patient's occupation.
- "2. It is caused by a frequently repeated or a continuous exposure to a substance or to a specific industrial practice which is hazardous and which has continued over an extended period of time.
- "3. It presents symptoms characteristic of an occupational disease which is known to have resulted in other cases from the same type of specific exposure.
- "4. It is not the result of ordinary wear and tear of industrial occupation or the general effect of employment or the kind of illness that results from contacts or activities in life outside of the patient's occupational pursuits."

In order to make reporting as uniform as possible and prevent its becoming burdensome, the following suggestions are therefore made: All disabilities arising out of occupation, whether they are on the schedule or not, whether disabling or not, whether causing lost time or not, should be reported, *provided* the disability will meet the definition of an occupational disease as defined in the above act.

## DECOMPRESSION OF THE SMALL BOWEL BY INTESTINAL TUBE DRAINAGE AT SITE OF OBSTRUCTION\*

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Any discussion which refers to intestinal obstruction must take cognizance of the vast amount of literature on this subject. A study of the contributions to this subject for the past sixty years indicates the small progress made in the treatment of this condition. Treves<sup>7</sup> indicated in 1884 that the current mortality from intestinal obstruction was approximately 60 to 70 per cent. Schramm<sup>6</sup> indicated that some progress had been made in the period from 1873 to 1883, when his statistics showed a mortality for cases operated prior to the former date of 73 per cent, while in those cases collected from 1873 to 1880, the mortality was 58 per cent. This, of course, may illustrate

nothing more than the expected variation in series or it may mean improvement in operative procedure. Compared to the sta-

\*Read before the seventy-second annual meeting of the Michigan State Medical Society in Grand Rapids, September, 1937.



tistics of today, the decrease in mortality figures is none too heartening. Miller<sup>4</sup> reported a mortality of 61 per cent in 1929, McIver<sup>5</sup> of 44 per cent in 1932.

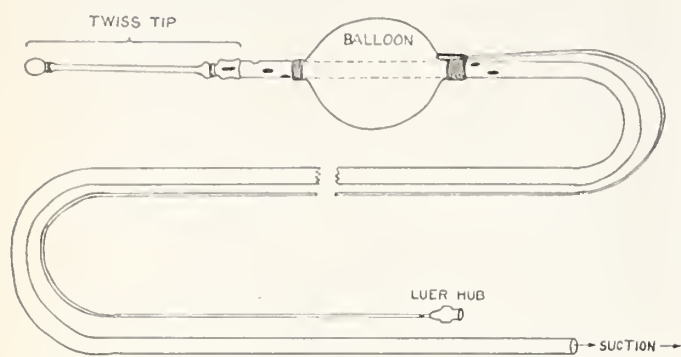


Fig. 1. Diagram of tube for small intestine intubation.

Experimental work on the nature of the cause of death in intestinal obstruction has progressed ahead of the clinical advances in this subject. The rôle of the two cardinal features of intestinal obstruction, distention, and loss of fluid and salt are better understood today. Convincing data regarding the rôle of these two features has been presented by Hartwell and Hogue,<sup>1</sup> Herrin and Meek<sup>2</sup> and others. One hears very little discussion today concerning the rôle of the absorption of toxic materials in intestinal obstruction, and while the possibility of toxemia playing an important rôle in the cause of death has not been ruled out completely by experimental studies, there is sufficient evidence at hand to point out that death may result from intestinal obstruction without absorption of toxic materials from the obstructed gut.

Relief of the cardinal features of intestinal obstruction, distention and loss of fluid and salt therefore are of primary importance in the treatment of this condition. Corrective operation during the period of acute obstruction is always hazardous and usually difficult. Relief of the distention has been afforded frequently by the expediency of an enterostomy just above the point of obstruction. This procedure is not without danger to the patient ill from intestinal obstruction, but in cases of mechanical block does allow decompression of the dilated gut. Since the popularization of gastric or duodenal siphonage by Wangenstein and his associates there has been a definite decrease in the number of enterostomies performed. It is frequently possible to tide the patient over his acute illness by the use of gastric or duodenal siphonage

and adequate intravenous fluids. Wangenstein has pointed out that this form of treatment does not mean that there is no place for enterostomy in the treatment of intestinal obstruction, since an enterostomy has the advantage of allowing the patient to be fed, a definite deficiency in treatment by siphonage. There are those who decry the use of suction drainage on the basis that it delays operative procedure and operation if performed, must be performed early for best results. Just as in the case of ruptured peptic ulcer, the mortality increases with delay. In those cases where drainage of the upper reaches of the intestine does not decompress the distended loop of bowel above the obstruction, siphonage of the material from the stomach or duodenum may cause delay in proper operative intervention if too much dependence is placed on it.

Several years ago it occurred to us that a combination of the features of enterostomy and duodenal siphonage would afford the ideal in treatment of small bowel obstruction. If it were possible rapidly to pass the drainage tube to the point of obstruction, this objective might be obtained. Tubes have been passed far into the intestinal tract but prior to the work of Abbott and Miller, the passage of the tube was quite time-consuming. Abbott and Miller, by using an inflatable balloon on the end of the intestinal tube, were able to pass the tube to the lower ileum within 6 hours. The use of such a tube would permit actual drainage of the distended loop as effectively as would an enterostomy and should likewise have the added feature that the entire gut above the obstruction would be swept clean of fluid and gas as the tube progressed.

Three years ago, Dr. Wm. O. Abbott and myself prepared to try this method of treatment in selected cases of intestinal obstruction and found that the tube could be passed far down the small intestine even though obstruction was present.

In this communication, I would like to discuss the indications, contraindications and procedure of this type of treatment. The tube for use is similar to that described by Abbott and Miller<sup>5</sup> and consists of a 16 to 18 gauge rubber tube, 10-12 feet in length at the lower end of which is attached a balloon (Fig. 1). In order to inflate the

balloon a fine stiff rubber tubing extends the full length of the larger tube and is attached to the balloon. Several holes are made in the lower end of the large tube to allow free entrance of fluid. The procedure for making these tubes is quite simple. The tube with the balloon empty is passed through the nose and slowly into the duodenum as is any ordinary duodenal tube. We have found the use of the Twiss tip of advantage in getting the tube into the duodenum. After the tube is well into the duodenum about 10 cubic centimeters of air is injected into the balloon to give bulk. The tube is then passed slowly further until about a foot more of tubing is passed. The balloon is then inflated so that it has a volume of at least 30 c.c. The tube can then pass more readily downward propelled by peristalsis as the gut below it is decompressed. In cases where speed of insertion is required this procedure can be carried out under fluoroscopic control. This is, however, usually not necessary. During the passage of the tube, it is quite necessary to keep the tube from blocking by constant irrigation, as the material removed is usually quite thick. After the tube has decompressed the bowel completely, the patient is allowed to eat a low residue diet, especially one lacking in fiber. As a rule the tube requires only occasional irrigation after it has reached its objective of primarily decompressing the bowel. Fluids and salt lost through the tube must be replaced, and since these patients are usually dehydrated, they must receive additional fluid during the early part of their treatment.

Possibly the best way to discuss the indications and contraindications relative to this type of treatment is to present cases which illustrate and answer some of the fears which were prominent in our minds at the beginning of our work. The most prominent of these was that we might attempt to treat cases in which there was non-viable gut. We have been careful therefore to exclude all cases in which there were strangulated herniæ. It is probable that cases of internal strangulation might be overlooked, but usually careful examination and history suggest their presence by the relation of onset of pain to distention, and the tenderness of the abdomen. Small Richters herniæ are likewise liable to be

overlooked. We have in our series one such case of an 81 year old obese woman who had intestinal obstruction of two days duration. She had a diaphragmatic hernia and it was impossible to pass the tube from the thoracic portion of her stomach. Nevertheless, her abdomen became softer and her general condition improved. She had several bowel movements on two successive days. She however became suddenly worse, her abdomen became tender, and again distended, and she died within 8 hours after the re-occurrence of her symptoms. At post-mortem the diaphragmatic hernia was found not to be causing her obstruction as supposed, but there was present peritonitis resulting from a small Richters hernia at the left internal femoral opening. This was unquestionably a case of mistaken diagnosis; whether operation would have changed the result is beside the point.

The subject of the rarer forms of obstruction with strangulation which may not be diagnosed permits of some reassurance from a study of statistics on intestinal obstruction.

Intussusception, volvulus, internal herniæ, Meckel's diverticulum and congenital anomalies, caused in McIvers<sup>3</sup> group of cases but 11.1 per cent of the total number of cases or 19.1 per cent of all cases except external herniæ. In this latter condition there should be little trouble with the diagnosis. The mortality in the group, excepting external herniæ, was 44 per cent. A comparison of the total possibility of error in diagnosis to the mortality figures indicate that should the non-operative procedure carry with it an appreciable decrease in the death rate in the cases for which the procedure is intended there is a good possibility of decreasing the total mortality in cases of intestinal obstruction. At present our mortality of cases which we have decompressed with the tube is approximately 10 per cent. We have not, of course, attempted the use of the tube in cases of strangulation when diagnosed. Cases of strangulation obstruction should not have conservative treatment except possibly for mesenteric thrombosis. Changes in the color of the gut so frequently seen in simple acute intestinal obstruction without interference with the mesenteric blood supply is the result of distention and has caused us no concern since, with the release of the



tension within the gut, the blood supply should be adequate. Two of the cases in which we failed were individuals who died, one within two hours, the other within six

ated, but I feel sure that time has released more adhesions than have surgeons. I am a bit unwilling to perform his fourth abdominal operation so long as I can follow



Fig. 2. Marked distention of small bowel. Peristalsis visible on admission. Duodenal suction drainage not effective.



Fig. 3. Decompression of small bowel complete with tip of tube in lower ileum just above point of obstruction.

hours after being seen. The fourth case was operated upon, an enterostomy being done, despite the presence of an unrecognized peritonitis. The reasoning from statistics as I have attempted in the above cannot be used as a criterion for the success of treatment by the long tube, but it does afford assurance to permit us to carry on our studies.

The next fear which confronted us was that we were relieving the immediate danger, but were not correcting the cause of the obstruction. This is undoubtedly true in many instances, and we have operated but few cases of our group. One had an enterostomy performed which I have mentioned; another was a man with complete obstruction who was never in condition for operation until almost a month after therapy was started, and who was finally operated and the obstruction relieved. This case will be discussed later. One of our cases has been relieved from his obstructive symptoms four times and has now been free of symptoms for four months. I suspect that he may ultimately have to be oper-

ated, but I feel sure that time has released more adhesions than have surgeons. I am a bit unwilling to perform his fourth abdominal operation so long as I can follow

him and keep him in good health by intubation. One other problem which will always confront us is that perhaps duodenal siphonage would have done just as well. Duodenal siphonage can remove only material forced up from below and there must needs be tension developed to accomplish a reversal of the flow (Figs. 2 and 3).

The following case as well as several others in our series developed obstruction during duodenal siphonage. Two cases are worthy of citation in this regard.

K. A. was a forty-year-old Armenian who had an appendectomy with drainage in 1931. He entered the hospital with an obstruction in a large ventral hernia and was operated. A portion of the ileum was resected. There was considerable spill at the time of operation, and a drain was left in the wound. He was placed on duodenal siphonage but on the fifteenth day, his temperature increased and he became distended. Examination through the drainage tract revealed retroperitoneal cellulitis. He was kept on siphonage drainage with adequate intravenous fluids, but his distention and general symptoms became worse. His distention disappeared with long tube drainage and he was relieved of his obstructive symptoms.

The other case which illustrates this point was D. P., aged thirty-one, a filling station attendant

who was shot through the stomach by a bandit. Prior to this catastrophe, he had been losing weight and had had all his teeth removed because of ill health, one and a half weeks before. His weight on admission was less than 100 pounds. At exploration a large through and through bullet wound in his stomach was repaired and a branch of the colic artery which was severed was ligated. There was a large quantity of blood in the peritoneal cavity. In order to keep his stomach empty, continuous duodenal suction was employed. After eight stormy postoperative days it became evident that he was completely obstructed and was rapidly losing ground. A long tube was passed into his terminal ileum and his abdomen became scaphoid and he was comfortable. However, two days later his tube became blocked after relatives had supplied him with oranges to eat, and he became rapidly worse. The tube was removed and the openings found to be blocked with orange pulp. It was cleaned and reinserted. He gained strength on this therapy and after having had the tube for over three weeks with no evidence of release of his obstruction, operation was performed. The intestines were matted together but were not dilated except for about 4 inches situated about 8 inches above the ileocecal valve where the gut was firmly bound and kinked. The tube was found to be within 6 inches of the obstruction and the gut was of good color. He left the hospital twenty-three days after operation, and has since resumed his work. He is now in fair health. Decompression permitted operation in this case which would otherwise have terminated fatally.

We have likewise been successful in passing the tube through the terminal ileum in a case of postoperative paralytic ileus. The propulsion of the tube might not have been expected since peristalsis was not active. Apparently in this case the intrinsic innervation of the small gut was sufficient to carry the tube along.

G. L. was a sixty-two year old man who developed paralytic ileus after a suprapubic cystotomy. This patient was operated July 1, 1937, at which time suprapubic cystotomy for vesical calculus was done. On the same day of his operation he became markedly distended, belched large quantities of gas, and could not eat or take fluids. Wangenstein suction relieved his distention somewhat, but periodically his abdomen became quite tense. On the night of July 2, a flat plate of the abdomen showed a marked paralytic ileus, many of the loops of small bowel being three to four inches in diameter. The tube was inserted on the evening of July 9. The following morning another flat plate of the abdomen was taken and showed the tip of the tube to be just past the ligament of Treitz. The balloon was then distended and the tube passed down into the intestinal tract rapidly. He was quite relieved of his distention by early afternoon, and by the following morning his abdomen was quite flat and the patient was eating and drinking fluids. The tube was removed on the twelfth, and the patient was given proctoclysis and catharsis. He had some slight distention later which was easily controlled by catharsis and enemata and was able to eat and drink normally.

An additional advantage of the tube is that it allows a localization of the point

of obstruction in many cases (Fig. 4). With the tube at the point of obstruction the danger from introduction of barium in oil is minimized. If a partial obstruction



Fig. 4. Barium injected down tube outlining obstruction in lower ileum.

should become complete, the small amount of barium necessary to outline the point of obstruction may be washed out of the intestine through the tube. In the majority of our cases, this material passed readily through the intestinal tract after the distention was relieved even though the obstruction appeared complete at the beginning of therapy.

At Receiving Hospital and the Department of Surgery, Wayne University College of Medicine, a group is studying the general problem of intestinal obstruction. It is only just that I mention that I have had associated with me in this work Dr. Wm. Osler Abbott of the University of Pennsylvania, Dr. Kenning and his associates at Receiving Hospital, and have had the coöperation of an interested and alert house staff. There is seldom a period when there is not more than one case of intestinal obstruction on the wards of Receiving Hospital. Fortunately for our studies the majority of those cases were postoperative cases. It is only fair to state that relatively few were operated in Receiving Hospital, but were sent to us by the City Physicians as emergency cases.



## Summary

A non-operative method for decompressing distended small intestine which combines features of suction drainage and enterostomy is presented.

Possible pitfalls arising from the use of this method in small bowel obstruction are discussed with relation to illustrative cases.

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## REVIEW OF A CASE OF THROMBO-CYTOPENIC PURPURA TREATED BY SPLENECTOMY\*

GEORGE T. AITKEN, M.D.

GRAND RAPIDS, MICHIGAN

Splenectomy for thrombo-cytopenic purpura is neither a new nor unusual therapeutic procedure. It is believed that this case warrants reporting, though, for two reasons: (1) There is a careful check on the patient's clinical and blood picture for one year postoperatively, and (2) the original diagnosis was a contested one.

The patient, a six-year old, white male, first came under our observation on September 26, 1933. Two years previously he had been treated at another hospital for a compound fracture of the right tibia and fibula which was complicated by an osteomyelitis, but the end-result was satisfactory. He had only to wear a short caliper brace. During one of his return visits to this other hospital for a check on his osteomyelitis, it was necessary to admit him because of frequent severe nose bleeds. His hemaglobin at this time was below 50%, and the red blood count varied between two and three and one-half millions, with a consistent decrease in the number of platelets. In August, 1932, he was discharged from this other hospital with a secondary diagnosis of thrombo-cytopenic purpura. Early in 1933 he was again admitted to the other hospital with a sore throat. At this time nasal mucous membrane hemorrhages were severe enough to necessitate several transfusions of whole blood. Three months later a detailed blood study revealed

Red blood cells.....	3,260,000
White blood cells .....	3,700
Hemoglobin (Sahli) .....	36%
Polymorphonuclears .....	52.5%
Large lymphocytes .....	3.0%
Small lymphocytes .....	34.5%
Monocytes .....	7.5%
Eosinophiles .....	2.5%
Platelets reduced. Red blood cells small, pale and round.	

From this a diagnosis of aplastic anemia was made. The old diagnosis of thrombo-cytopenic purpura which was made in 1932 was refuted. A tonsillectomy and adenoidectomy was done. Transfusions, pigeon serum and snake venom were used in a supportive manner. The mucous membrane and subcutaneous hemorrhages persisted. At this time the patient was transferred to the Orthopedic Clinic at Blodgett Memorial Hospital.

From September, 1933, until June, 1935, the patient was followed in Grand Rapids. During this period it was necessary to keep him in the Convalescent Home a great portion of the time because he had chronic, intermittent hemorrhages from the nasal mucous membranes and under the skin. These hemorrhages were severe enough to necessitate transfusions varying in quantity from 250 c.c. to 500 c.c. at a time. His blood count was checked frequently and remained about as reported from the other

hospital. There was a consistent reduction in platelets and at no time were ever more than 10,000 reported. The bleeding time remained prolonged, but the clotting time normal. Transfusions seemed to be only palliative, and snake venom gave no relief.

In June, 1935, the patient was again referred to the other hospital for re-examination and a review of his condition. At that time they reported his detailed blood work as follows:

Red blood cells.....	3,200,000
White blood cells.....	4,600
Hemoglobin (Sahli).....	47%
Polymorphonuclear neutrophils.....	49.0%
Large lymphocytes .....	22.0%
Small lymphocytes .....	10.0%
Monocytes .....	11.0%
Eosinophils .....	6.0%
Basophils .....	2.0%
Plasma cells were present. Platelets were practically absent. No basophilia of the granules of the neutrophils. Reticulocytes about 3.0%.	

At this time the diagnosis of hypoplastic anemia was again advanced and splenectomy was advised against. They stated that there was not a selective decrease of the platelets, but rather a total decrease of all of the blood elements.

The patient was then returned to Grand Rapids on a régime of 1 c.c. every second day of staphylococcus toxoid No. 1 until the vial was finished, then a course of staphylococcus toxoid No. 2 tri-weekly. This helped somewhat, but towards the fall of 1935 the patient apparently became refractive to this medication and his chronic, intermittent nasal and subcutaneous hemorrhages recurred.

A peculiar feature of his bleeding, noticed at this time, was that it appeared to be cyclic without a constant time interval and preceded by a definite lethargy and feeling of apprehension. Those in

\*From Surgical Department, Blodgett Memorial Hospital, Grand Rapids, Michigan.

charge of his care at the Convalescent Unit were able to accurately predict periods of bleeding.

In October of 1936 a complete review of this patient's findings was made and further blood studies were done. The blood picture was about as previously shown. There was still a leukopenia with a relative lymphocytosis. In the presence, however, of reticulated red blood cells and persistent hemorrhages it was felt that hypoplastic anemia could be ruled out. Clinically, the patient, now a ten-year old white male, was pale and apprehensive. The tourniquet test was positive and his clotting time was delayed. There was, however, no palpable enlargement of the spleen.

After consultation and much discussion splenectomy was decided upon. Our decision was undoubtedly influenced by the fact that the child was rapidly losing ground from a physical standpoint. His hemorrhages were more frequent and his recuperative powers were diminishing.

He was prepared for surgery by a 500 c.c. transfusion of whole blood. The usual technic was employed at the time of operation and a slightly enlarged spleen was removed. Microscopically, the spleen presented the following picture: "Sections show interstitial fibrous tissue hyperplasia, congestion, reticulo-endothelial hyperplasia, numerous eosinophils in the sinusoids. Much phagocytic activity."

Eleven days following surgery the patient received another transfusion of 300 c.c. of whole blood. His postoperative recovery was uneventful and he was discharged from the hospital to the Convalescent Unit. He was there for fifteen days, after which he was discharged to his own home to go to regular school and resume normal activity.

On May 25, 1937, he came into the clinic stating that he had bled about fifteen drops from his nose. There was a history of trauma. Observation for several days revealed no evidence of hemorrhagic tendencies, so the boy was discharged to his own home and regular school.

A careful postoperative check of the blood picture showed an irregular increase in the number of platelets. The average of the increase was below that usually reported in literature. (See table.) Eosinophilia was marked about six weeks postoperatively. There was a steady rise in the red blood cell count and hemoglobin reading with a maintenance of the same. Clinically, the patient was much improved. He gained weight, his color returned, and his apprehension disappeared. A chronic invalid became a

TABLE I

Date	RBC	Hgb.	Platelets	Bleeding time	
				Min.	Sec.
3-10-32			10,000		
1933			10,000	4	
3-28-35	6,050,000	100%	10,000	20	
1935			10,000		
10-30-36	2,540,000	35%	Insufficient to count		
11-11-36	2,950,000	45%	Insufficient to count		
11-15-36			Insufficient to count		
11-16-36			Insufficient to count		
11-23-36	3,750,000	55%	10,000		
11-24-36	3,120,000	50%	10,000		
11-25-36	3,550,000	50%	22,000		
11-26-36	3,420,000	50%	18,000		
11-28-36	3,610,000	50%	21,000		
11-29-36	3,790,000	50%	15,000		
11-30-36	3,920,000	55%	10,000		
12- 1-36	3,970,000	45%	18,000	4	
12- 2-36	4,500,000	60%	14,000		
12- 3-36	4,600,000	60%	18,000		
12- 4-36	4,450,000	70%	18,000		
12- 5-36	4,560,000	65%	20,000		
12- 7-36	4,520,000	65%	14,000		
12-19-36	3,900,000	65%	175,000		
12-26-36	4,250,000	70%	85,000		30
1- 2-37	4,500,000	80%	60,000		30
1- 9-37	4,340,000		110,000	4	30
1-16-37	4,450,000	70%	30,000		
1-21-37	4,450,000	70%	30,000	1	30
1-23-37	5,400,000	85%	30,000		
1-30-37	5,420,000	80%	30,000	3	
2- 6-37	4,550,000	80%	35,000	6	45
2-13-37	4,940,000	85%	30,000	1	30
2-20-37	4,420,000	80%	30,000		45
2-27-37	3,650,000	70%	35,000	1	30
3- 6-37	4,260,000	80%	25,000	1	30
4-22-37	4,150,000	80%	70,000	1	20
5-22-37	5,000,000	85%	30,000		30
6-26-37	4,290,000	80%	48,000	1	
10- 7-37			75,000		

normal individual pursuing a normal, daily routine of living.

### Summary

1. We present a case of chronic purpura hemorrhagica which in an acute exacerbation had a splenectomy.

2. One year's careful check on this patient reveals a clinical cure without the usual increase in the number of platelets.

3. An enlarged spleen was not demonstrated preoperatively, but after removal it was found that there was a true splenic enlargement.

4. Eosinophilia was a transitory sequelæ of splenectomy in this case.

### Hypoparathyroidism: Treatment of Chronic Cases

Under carefully controlled conditions, R. H. Freyberg, R. L. Grant and M. A. Robb, Ann Arbor, Mich. (*Journal A. M. A.*, Nov. 28, 1936), measured in two patients the effect of various remedies frequently employed in the treatment of chronic postoperative parathyroid tetany. The data obtained indicate that in order to compensate most satisfactorily for the altered state of calcium and phosphorus metabolism, the intake of phosphorus should be low and the calcium intake high. This can best be accomplished by feeding a low phosphorus diet (which will also be low in calcium) and large amounts of calcium salt, other than a phosphate. The commonly employed high calcium (milk) diet is undesirable because of its high phosphorus content. A solution of calcium lactate, in amounts sufficient to provide from 1.5 to 2.5 gm. of calcium daily, is in many respects the best method of administering calcium. Vitamin D in large amounts is of definite value and should be given. Hydrochloric acid and magnesium

carbonate were not beneficial. Thyroid substance should be administered, if hypothyroidism exists. Improvement in calcium and phosphorus metabolism that could be attributed definitely to thyroid medication was not observed. Although substitution therapy, consisting of the subcutaneous or intramuscular injection of parathyroid extract, is the most specific treatment, there are serious objections to the long continued use of this extract. If successful management can be accomplished without the use of parathyroid extract, it is advisable not to use it. Patients with severe chronic hypoparathyroidism can be maintained in a state of good, if not perfect, health without the use of parathyroid extract. The effectiveness of parathyroid extract when injected intravenously into a patient who had become "immune" to the extract injected subcutaneously suggests that "refractivity" to parathyroid extract is due to a localization of destruction of the active principle at the site of its injection.



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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### EDITORS DO NOT ENDORSE

DR. Walter C. Alvarez of the Mayo Clinic certainly knows what he is talking about when he comments editorially in the *American Journal of Digestive Diseases* on the editor's problems: "One of the everyday problems of editors of medical journals is what to do with papers reporting brilliant results in the treatment of disease with some new drug." He continues, "Every student of therapeutics knows that every time a new drug catches the fancy of physicians or proves to be useful in one small field of disease, it is immediately tried out extensively for the relief of almost every known malady."

Dr. Alvarez goes on to mention the fate of quinine found helpful in malaria over a

hundred years ago, which was tried out in the treatment of all other fevers. Subsequently, it was supposed to be a great tonic, but at the present, the careful physician is inclined to limit its use to the treatment of malaria. The foul smelling and foul tasting creosote, hailed as one of the fixed stars of therapeutics, particularly in the treatment of tuberculosis, has happily fallen into complete disuse. Today, sulfanilamide occupies the spot in the center of the stage. Time will doubtless deal with it as it has with other drugs whose merits have been loudly proclaimed.

The policy of THE JOURNAL of the Michigan State Medical Society has been to refrain from endorsing drugs or medicinal agents. This is all left to the council on Pharmacy and Chemistry of the American Medical Association, whose endorsement is accepted. When a contributor writes up his experience with a drug, not endorsed by the Council, he is responsible for his own comments on its use. If they are too enthusiastic, the enthusiasm should react not to his advantage.

Dr. Alvarez comments very interestingly on the editor's experience as follows:

"Often then, as an editor looks at the pile of therapeutic reports that come to his desk, his tendency is to send them back; he hates to think of padding the files of his journal with a mass of articles which are almost certain to be worse than useless later. But then he will wonder, 'Perhaps there is a grain of truth here, and I should not be denying it publication.' But, as he rereads the long article with all its case reports, he asks, 'Is all this necessary? Why couldn't the man have said simply that he tried so-and-so's new medicine in thirty cases of ulcer, and his impression was that the patient did better than they would have done on diet and Sippy powders alone?' What reams of paper this would save, and actually how often the writer's object would be better served with the short, pithy, readable report than with the long tiresome one.

"Other physicians, noting such a report, might be induced to make similar studies; they also might make short reports, favorable or unfavorable, and soon the rank and file of the medical profession would gain a good idea of what drugs are worth trying and what are not. Unfortunately, today, few men write unfavorable reports, perhaps because they assume that every paper must be a long and detailed one, and they haven't time to spend over a 'dead horse.' Actually, how helpful and simple it would be if soon after a new and popular drug was introduced, notes like this would appear: 'I tried the drug in such and such dosage in twenty cases of this and that with apparently good beginning results in some. In two cases the results seem to be fairly permanent. In several cases I had to stop administration because of abdominal pain, diarrhea, and skin eruptions, and in one case the patient promptly died with a severe leukopenia. I have decided to stop using it. Signed .....'"

## INFORMING THE LAYMAN

PERHAPS there is no subject of greater interest to the average layman than that of how to maintain the best possible health, and perhaps there is none other about which such erroneous and bizarre views are held. The function of the Joint Committee on Health Education, now sixteen years old, has been to provide the need with knowledge which is accurate and simple.

Since its organization, by means of lectures, by radio and through the public press, hundreds of thousands of persons in this state have been reached and the reception has been most enthusiastic. There is, however, a great deal to be accomplished. The work continues and will never end so long as there are willing listeners and readers.

"The function of the Joint Committee," as quoted by Dr. B. R. Corbus, chairman of the recent annual meeting in Ann Arbor, "is to present to the public the fundamental facts of modern scientific medicine for the purpose of building up sound public opinion relative to the question of public and private health. It is concerned in bringing truth to the people; not in supporting nor attacking any school, sect or theory of medical practice. It will send out teachers, not advocates." The Joint Committee has been true to its ideals. Its object, namely, to inform rather than to propagandize, has been adhered to all the years of its existence.

To the initial units composing the Joint Committee on Health Education, others have been added until the committee now represents twenty-seven unit organizations.

Dr. Corbus, in his annual address emphasized the need for effectual presentation of matters of health to the school child. Any long range view is justified. The schools are the proper places to acquire habits which will be beneficial all through life. He spoke of the valuable aid by the Medical profession and of the importance of follow-up efforts by teachers where these lectures are given in schools. With this object in view, two bulletins, "The Problem Solving Approach in Health Teaching," and "Health Goals for the School Child," have been prepared. The matter has further been an integral part of the program of the various state teachers' colleges. The State Department of Health has coöperated to the extent of securing certain federal grants whereby

members of the faculties of various teachers' colleges may attend the University of Michigan for a year of special training in hygiene and public health.

The Joint Committee maintains a lecture bureau, and coöperating with the Michigan State Medical Society, it has been responsible for radio programs. The committee is also in a position to furnish speakers to lay adult audiences, parent-teacher associations, noon-tide clubs and any other group which may manifest an interest in the subject.

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 TO CONTRIBUTORS TO MEDICAL JOURNALS

WITHIN the past few years, a number of small pocket-sized digests have come into existence and are apparently thriving. Everyone is acquainted with the *Reader's Digest*, which has been before the public for two decades. Many others might be mentioned. The fact that these publications flourish indicates a demand on the part of the reading public for short articles or digests of articles which have appeared in larger lay magazines.

A similar situation is manifesting itself in medicine. It is simply impossible for the average physician or specialist in the time at his disposal to read all that he really should in order to keep abreast of the times. This JOURNAL has endeavored to meet the situation in a small way by publishing condensed abstracts of articles appearing in the *Journal of the American Medical Association*. We would like to carry the idea farther and publish abstracts of papers presented before county societies in the state, as well as before the various specialist groups in the larger cities. The demands for space in state journals continues to be more pressing, so that editors, as a rule, have enough acceptable copy on hand to supply their pages months in advance of the date of publication. The brief article or digested article would fill the purpose and at the same time make room for a larger number of others.

There are times when a paper of monograph size is in order, particularly if the writer is an outstanding student in his particular subject. The short concise paper of a thousand to twelve hundred words, other things being equal, will be read, while the



long paper, which is set aside for later perusal, may be completely sidetracked for something else.

### THE GROUP HOSPITAL INSURANCE PLAN

ONE objection to the Group Hospital Insurance plan comes from the physician whose patient may have paid for hospitalization in a hospital or member of a group of hospitals in which the doctor has no access. Should the patient insist on going to the institution where his hospital bills were paid by his insurance, which he probably would, he would be required to waive his right to his personal physician's services and the patient and physician would be separated. Or if the physician happened to be on no hospital staff, he would find the group insurance plan to interfere materially with his practice, especially where it was necessary to hospitalize his patients.

The group insurance idea would also discriminate against those physicians who conduct small hospitals, efficient in every way, but which, from their size, might not be eligible to endorsement by the council on standardization of hospitals.

Again there is a strong disposition for a person to make use of anything he has paid for. Therefore, an indisposition which would ordinarily confine him to his home for a brief time, would take him to the hospital, and, if there were many like him, hospital accommodation would be at a premium.

THE JOURNAL welcomes letters from its readers, brief and to the point, on the subject. Let us have the pros as well as the contras.

### SENATOR ROYAL S. COPELAND

THE death of Senator Royal S. Copeland has removed from public life a person whom Michigan had claimed as her own, for Dr. Copeland was born and educated in this state. At one time a lecturer at the University of Michigan, he was an example of what one with specialized training may accomplish outside his chosen professional career. Throughout his political life, his acts were characterized by that independence of thought and action which marks the physician. Commenting editorially, the *New York Times* said:

"It was Mr. Copeland's lot never to be an ally of the Government in power. First elected to the Senate in 1922, he came into that assembly in the heyday of Republican triumph following the first post-war reaction. He served through the Twenties under three Republican Administrations. When the tide turned, following the great depression, and a Democratic Administration came into power, it proved to be a Democratic Administration to which he was willing to give only an intermittent loyalty. He was even less in tune with the prevailing doctrines of his own party at the close of his long career than he was with the doctrines of the opposition when he first entered national office.

"Industry, independence, a specialized knowledge in several useful fields, an inexhaustible capacity for making new acquaintanceships and a natural flair for politics are among the qualities which explain the rôle that Mr. Copeland played in New York and in the nation."

The daily press has commented adequately on his career at the time of Senator Copeland's death. We would comment only on the physician as a legislator. In Michigan, it has been a rare exception that doctors have sought political preferment. In Ontario there are, or were within the past three or four years, twelve physician members of the legislature. Doctors as a rule have not the time to devote to the affairs of state—so much the worse for the state. The physician's training and experience is such that he is able to keep both feet on the ground; he is not swayed by every transitory notion. His services would be valuable to the state and nation not only so far as health legislation is concerned but in other fields as well.

With a reputation as poor business men, doctors during their professional careers have seen business firms rise and fall by the score and still the doctors carry on. They have witnessed the obsequies of many business firms that have had their day and have ceased to be. The physician's reputation as a poor business man is undeserved. The state might therefore profit from the doctor legislator's business acumen. The service rendered the United States by the late Senator Copeland is evidence of what may be accomplished by the medically trained mind.

### ABOUT LEASES

THE subject of leases, like taxation and the wolf at the door, is one of the things that is a constant reminder of the stern necessities of life to a great many of us. We have seen copies of the regulation lease for space in downtown office buildings. The impression one gets is that the company had hired a lawyer who feels it is his duty to

work in the company's interest, one hundred per cent. As a result, the average lease binds the tenant body and soul both here and hereafter, should he pass over to the great beyond before its expiration, inasmuch as his heirs are also bound by the lease.

In justice, a clause should be added in the interest of the tenant to preserve his right to life, liberty and the pursuit of happiness. We would suggest a paragraph in effect as follows: "In the event of disabling accident, or prolonged incapacitating illness, or any condition which is commonly described in legal phraseology as an 'act of God,' that would render the professional tenant unable to carry on the occupation for which he was trained, the unexpired portion of the terms of the lease will be declared null and void and the sum due for the unexpired portion cancelled." As the phrasing now stands, should a dentist or surgeon lose the use of his right hand through accident or otherwise, he might be able to eke out an existence in some non-professional calling but under the terms of the landlord, he would be obliged to continue to pay rent on an unoccupied office. It is a matter of simple equity that the interests of the tenant should be guarded equally with those of the landlord.

As a matter of fact, however, the relations of landlord and tenant as a rule are more humane. In other words, many managements waive the exaction of the pound of flesh where it is obviously impossible for a conscientious tenant to make good. However, as intimated, a more humane phrasing of the lease would provide a saving clause for the tenant as suggested corresponding to saving clauses for the landlord which hold the tenant when events transpire over which the landlord has no control.

The effect would be to promote a happier relationship between two persons who are mutually dependent.

#### The Name "Michigan"

The first known use of the name "Michigan" was in connection with the lake and occurs in the Jesuit Relations of 1712 wherein Pere Marest, a Jesuit Priest, writing of his return journey from Illinois to Mackinac, says, "We sailed the length of Lake Michigan which is named on the maps Lake Illinois without any reason since there are no Illinois Indians who dwell in its vicinity." The first application of the name to land appears in the proceedings of Congress in 1804-1805 which established the Territory of Michigan. The generally accepted translation of the name is "Great Lake."

#### SITTING BY THE INGLE

He was sitting by the ingle,\* sitting quiet and wond'ringly,  
He was doon intil the cushions, doon sae snug and bonnily,\*  
And his slippered feet were resting on the rug sae cozily,  
As he sat there by the ingle, dreaming dreams sae pleasingly.

He was meditating, lonely, thinking out a mystery,  
He was reading—sometimes reading—reading very studiously,  
He was nodding, often nodding, dozing quite unconsciously,  
While he sat there by the ingle, smoking, smiling joyously.

The flames were flying upward in a fascinating stream,  
There were sparks of fire shooting, like the stars in Heaven's gleam.  
The scene at once resplendent lends a joy to me supreme,  
As he sits there by the ingle in the glory o' his dream.

Oh that ye could live forever in this pleasant ecstasy,  
And your friends be ever wishing, be wishing wistfully,  
That in the evening hours of life when Heaven calls its call to thee  
Ye'll be found there by the ingle, resting calm and peacefully.

WEELUM

\*ingle—hearth, fireplace.

\*bonnily—nicely, pretty.

#### Rationale of Sulfanilamide in Gonococcic Urethritis

One of the authors (Farrell) has treated ten cases of gonorrheal urethritis with sulfanilamide by mouth. Only five of the patients responded to treatment. The other five seemed to derive little benefit from the drug, as evidenced by persistent discharge, so that local treatment was begun. None of the ten patients had any complications such as posterior urethritis, prostatitis or epididymitis. Because of the repeated observations by the various observers that no complications occur, it seemed advisable to James I. Farrell, Evanston, Ill.; Yale Lyman and G. P. Youman, Chicago (*Journal A. M. A.*, April 9, 1938), to determine a rational basis for the use of sulfanilamide in gonorrhea. Large male dogs were used in their experiments. The dogs were given sulfanilamide by mouth for several days, the daily dose being approximately 0.18 Gm. per kilogram. The prostatic fluid of two dogs which had received sulfanilamide intravenously after a sample of normal prostatic fluid had been obtained was tested for germicidal activity. Both samples were tested with *Bacillus coli* and only one with *Staphylococcus aureus*. The sulfanilamide is excreted in bactericidal concentrations, in both the urine and the secretion of the posterior urethra, when adequate doses are given. According to the experiments, from 10 to 15 mg. of sulfanilamide seems to be adequate antiseptic concentration. The experiments demonstrate that the bactericidal power of prostatic secretion on colon bacilli and *Staphylococcus aureus* is marked. In twenty-four hours all the bacteria were reduced in number. In dogs given sulfanilamide in approximately human doses, there were no viable bacteria on the plate at the end of twenty-four hours. The drug appears to act directly on the infecting organisms in the urinary tract.



# The 1938 Meeting

## OFFICIAL CALL

THE Michigan State Medical Society will convene in Annual Session in Detroit on September 19, 20, 21, 22, 1938. The provisions of the Constitution and By-laws and the Official Program will govern the deliberations.

Henry Cook, M.D.

President

P. R. Urmston, M.D.

Chairman of The Council

Philip A. Riley, M.D.

Speaker

Attest: L. Fernald Foster, M.D., Secretary

\* \* \*

## SESSIONS OF THE HOUSE OF DELEGATES

MONDAY, SEPTEMBER 19, 1938

Book-Cadillac Hotel, Detroit

8:00 A.M. Delegates' Breakfast, English Room

9:00 A.M. First Session, Grand Ballroom

3:00 P.M. Second Session, Grand Ballroom

8:00 P.M. Third Session, Grand Ballroom

## HOUSE OF DELEGATES, 1938

Book-Cadillac Hotel, Detroit

ORDER OF BUSINESS\*

MONDAY, SEPTEMBER 19, 1938

8:00 A.M. sharp—Delegates' Breakfast, English Room.

9:00 A.M. sharp—First Session, Grand Ballroom

1. Call to Order by the Speaker
  2. Report of Committee on Credentials
  3. Roll Call
  4. Appointment of Reference Committees:
    - On Officers' Reports
    - On Reports of The Council
    - On Reports of Standing Committees
    - On Reports of Special Committees
    - On Amendments to Constitution and By-Laws
    - On Resolutions
  5. Speaker's Address—Philip A. Riley, M.D., Jackson
  6. President's Address—Henry Cook, M.D., Flint
  7. President-elect's Address—Henry A. Luce, M.D., Detroit
  8. Annual Report of The Council
  9. Report of Delegates to American Medical Association.
  10. Reports of Standing Committees:
    - (a) Legislative Committee
    - (b) Representatives to Joint Committee on Health Education
    - (c) Committee on Distribution of Medical Care
    - (d) Cancer Committee
    - (e) Preventive Medicine Committee (and subcommittees on Degenerative Diseases: Pneumonia; Syphilis; and Tuberculosis)
    - (f) Committee on Postgraduate Medical Education
    - (g) Public Relations Committee
    - (h) Ethics Committee
    - (i) Medico-Legal Committee
- Recess

MONDAY, SEPTEMBER 19, 1938

3:00 P.M. sharp—Second Session, Grand Ballroom

1. Supplementary Report of Committee on Credentials
  2. Roll Call
  3. Reports of Special Committees:
    - (a) Maternal Health Committee
    - (b) Contact Committee to Governmental Agencies
    - (c) Mental Hygiene Committee
    - (d) Radio Committee
    - (e) Advisory Committee, Woman's Auxiliary
    - (f) Liaison Committee with Michigan Hospital Association
    - (g) Liaison Committee with State Bar of Michigan
    - (h) Committee on Health League
    - (i) Advisory Committee to Parole Commission
    - (j) Membership Committee
    - (k) Committee on Occupational Disease and Industrial Hygiene.
  4. Unfinished Business:
    - Report on group hospitalization
  5. Resolutions\*
  6. New Business\*
  7. Reports of Reference Committees:
    - (a) On Officers' Reports
    - (b) On Reports of The Council
    - (c) On Reports of Standing Committees
    - (d) On Reports of Special Committees
    - (e) On Amendments to Constitution and By-Laws
    - (f) On Resolutions
- Recess

MONDAY, SEPTEMBER 19, 1938

8:00 P.M. sharp—Third Session, Grand Ballroom

1. Supplementary Report of Committee on Credentials
2. Roll Call
3. Supplementary Report from The Council
4. Supplementary Report from Reference Committees
5. Elections:
  - (a) Councilors:
    - Eleventh District to succeed Roy H. Holmes, M.D., Muskegon
    - Twelfth District, to succeed F. C. Bandy, M.D., Sault Ste. Marie
    - Thirteenth District, to succeed B. H. Van Leuven, M.D., Petoskey
    - Seventeenth District, to succeed W. A. Manthei, M.D., Lake Linden
  - (b) Delegates to A.M.A. to succeed:
    - Henry A. Luce, M.D., Detroit
    - Thomas K. Gruber, M.D., Eloise
    - Jacob D. Brook, M.D., Grandville
    - Claude R. Keyport, M.D., Grayling
  - Alternates to succeed:
    - T. E. DeGurse, M.D., Marine City
    - C. S. Gorsline, M.D., Battle Creek
    - R. H. Denham, M.D., Grand Rapids
  - (c) Place of Annual Meeting
  - (d) President-elect
  - (e) Speaker of House of Delegates
  - (f) Vice Speaker of the House of Delegates
6. Adjournment

\*See the Constitution, Article IV, and the By-laws, Chapter 3, on the "House of Delegates."

\*All resolutions, special reports, and new business shall be presented in duplicate.

REFERENCE COMMITTEES

Credentials Committee

E. O. Foss  
A. G. Sheets, *Chairman*  
John A. Wessinger  
P. L. Ledwidge

On Officers' Reports

Founders' Suite  
Fifth Floor, Book-Cadillac Hotel

F. J. O'Donnell, *Chairman*  
Robt. B. Harkness  
L. W. Day  
A. E. Catherwood  
W. B. Cooksey  
C. F. Snapp

On Reports of The Council

Founders' Suite Annex  
Fifth Floor, Book-Cadillac Hotel

Donald R. Brasie, *Chairman*  
R. L. Wade  
A. V. Wenger  
R. H. Pino  
W. R. Clinton  
H. W. Wiley  
O. D. Stryker  
G. C. Penberthy  
A. L. Callery  
E. D. Spalding

On Reports of Standing Committees

Parlor H  
Fifth Floor, Book-Cadillac Hotel

Stanley W. Insley, *Chairman*  
A. T. Hafford  
R. E. Spinks  
Otto O. Beck  
G. H. Southwick  
G. H. Yeo  
H. Huntington  
L. J. Hirschman  
C. F. DeVries  
R. C. Jamieson  
W. E. Tew  
H. W. Plaggemeyer  
C. K. Hasley  
L. E. Coffin  
Chas. Ten Houten  
W. Joe Smith

On Reports of Special Committees

Parlor I  
Fifth Floor, Book-Cadillac Hotel

C. E. Umphrey, *Chairman*  
R. L. Finch  
J. A. Hookey  
A. L. Arnold, Jr.  
C. E. Dutchess  
R. A. Springer  
R. C. Perkins  
W. C. Ellet  
C. E. Lemen  
E. J. Evans  
R. J. Hubbell  
Palmer E. Sutton

On Amendments to Constitution and By-Laws

Parlor J  
Fifth Floor, Book-Cadillac Hotel

Wm. R. Torgerson, *Chairman*  
W. D. Barrett  
J. J. O'Meara  
J. M. Robb  
Fred M. Doyle  
T. K. Gruber

On Resolutions

Parlor G  
Fifth Floor, Book-Cadillac Hotel

F. E. Reeder, *Chairman*  
David I. Sugar  
S. C. Mason  
R. M. McKean  
C. R. Keyport  
C. E. Toshach

MEMBERS OF THE  
HOUSE OF DELEGATES, 1938

MICHIGAN STATE MEDICAL SOCIETY

Philip A. Riley, M.D., Jackson, *Speaker*  
Martin H. Hoffmann, M.D., Eloise, *Vice Speaker*  
L. Fernald Foster, M.D., Bay City, *Secretary*  
*Names of Alternates appear in italics*

1. **Allegan**  
E. T. Brunson, M.D., Ganges  
*O. H. Stuch, M.D., Otsego*
2. **Alpena-Alcona-Presque Isle**  
F. J. O'Donnell, M.D., Alpena  
*A. R. Miller, M.D., Harrisville*
3. **Barry**  
Robert B. Harkness, M.D., Hastings  
*H. S. Wedel, M.D., Freeport*
4. **Bay-Arenac-Iosco-Gladwin**  
R. C. Perkins, M.D., Davidson Bldg., Bay City  
*A. D. Allen, M.D., Allen Medical Bldg., Bay City*
5. **Berrien**  
Wm. C. Ellet, M.D., Benton Harbor  
*Fred Henderson, M.D., Niles*
6. **Branch**  
Robert L. Wade, M.D., Coldwater  
*Samuel Schultz, M.D., Coldwater*
7. **Calhoun**  
Harvey Hansen, M.D., Central Tower, Battle Creek  
*A. T. Hafford, M.D., Albion*  
*Wm. Dugan, M.D., Post Bldg., Battle Creek*  
*Norman H. Amos, M.D., Central Tower, Battle Creek*
8. **Cass**  
S. L. Loupee, M.D., Dowagiac  
*C. M. Harmon, M.D., Cassopolis*
9. **Chippewa-Mackinac**  
E. S. Rhind, M.D., Rudyard  
*J. A. Reese, M.D., DeTour*
10. **Clinton**  
A. C. Henthorn, M.D., St. Johns  
*D. H. MacPherson, M.D., Fowler*
11. **Delta**  
O. S. Hult, M.D., Gladstone  
*G. W. Moll, M.D., Escanaba*
12. **Dickinson-Iron**  
E. M. Libby, M.D., Iron River  
*W. H. Huron, M.D., Iron Mountain*
13. **Eaton**  
A. G. Sheets, M.D., Eaton Rapids  
*Paul Engle, M.D., Olivet*
14. **Genesee**  
Frank E. Reeder, M.D., 808 Genesee Bank Bldg., Flint  
Robert Scott, M.D., 1215 Detroit St., Flint  
Donald R. Brasie, M.D., 907 Citizens Bank Bldg., Flint  
*R. S. Halligan, M.D., 405 E. First St., Flint*  
*D. R. Wright, M.D., 405 W. Court St., Flint*  
*A. Dale Kirk, M.D., 300 E. First St., Flint*
15. **Gogebic**  
W. Ellwood Tew, M.D., Bessemer  
*M. J. Lieberthal, M.D., Ironwood*
16. **Grand Traverse-Leelanau-Benzie**  
C. E. Lemen, M.D., Traverse City  
*None*



17. **Gratiot-Isabella-Clare**  
Myron C. Becker, M.D., Edmore  
Charles F. DuBois, M.D., Alma
18. **Hillsdale**  
L. W. Day, M.D., Jonesville  
O. G. McFarland, M.D., North Adams
19. **Houghton-Baraga-Keweenaw**  
L. E. Coffin, M.D., Painesdale  
G. M. Waldie, M.D., Hancock
20. **Huron-Sanilac**  
J. C. Webster, M.D., Marlette  
C. W. Oakes, M.D., Harbor Beach
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R. L. Finch, M.D., 124 W. Lenawee, Lansing  
C. F. DeVries, M.D., 320 Townsend, Lansing  
H. W. Wiley, M.D., 300 W. Ottawa, Lansing  
Hewitt H. Smith, M.D., Tussing Bldg., Lansing  
O. B. McGillicuddy, M.D., Olds Tower, Lansing  
W. Cameron, M.D., American State Savings  
Bank Bldg., Lansing
22. **Ionia-Montcalm**  
L. E. Kelsey, M.D., Lakeview  
C. T. Pankhurst, M.D., Ionia
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Philip A. Riley, M.D., 500 S. Jackson St., Jackson  
James J. O'Meara, M.D., 608 Peoples National  
Bank Bldg., Jackson  
H. A. Brown, M.D., 701 Reynolds Bldg., Jackson  
C. S. Clarke, M.D., 605 Dwight Bldg., Jackson
24. **Kalamazoo-Van Buren**  
Charles Ten Houten, M.D., Paw Paw  
R. J. Hubbell, M.D., 1311 American National  
Bank Bldg., Kalamazoo  
Fred M. Doyle, M.D., 1315 American National  
Bank Bldg., Kalamazoo  
I. W. Brown, M.D., City Health Department,  
Kalamazoo  
Bert Diephus, M.D., South Haven  
J. G. Kingma, M.D., Decatur
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A. V. Wenger, M.D., Loraine Bldg., Grand  
Rapids  
C. F. Snapp, M.D., Medical Arts Bldg., Grand  
Rapids  
P. W. Kniskern, M.D., Medical Arts Bldg.,  
Grand Rapids  
G. H. Southwick, M.D., 55 Sheldon Ave., Grand  
Rapids  
W. R. Torgerson, M.D., Metz Bldg., Grand  
Rapids  
O. H. Gillett, M.D., Metz Bldg., Grand Rapids  
John Wenger, M.D., Coopersville  
Paul Willits, M.D., Medical Arts Bldg., Grand  
Rapids  
Ward Ferguson, M.D., 6 Park Place, Grand  
Rapids  
J. F. Whinery, M.D., Kendall-Professional  
Bldg., Grand Rapids
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Herbert M. Best, M.D., Lapeer  
D. J. O'Brien, M.D., Lapeer
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E. T. Morden, M.D., Adrian
28. **Livingston**  
H. Huntington, M.D., Howell  
J. J. Hendren, M.D., Fowlerville
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E. H. Campbell, M.D., Newberry
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Joseph N. Scher, M.D., Mt. Clemens
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E. A. Oakes, M.D., Manistee  
L. W. Switzer, M.D., Manistee
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Vivian Vandeventer, M.D., Ishpeming  
R. A. Burke, M.D., Palmer
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C. A. Paukstis, M.D., Ludington
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Glenn Grieve, M.D., Big Rapids
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S. C. Mason, M.D., Menominee  
Ed. Sawbridge, M.D., Stephenson
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Edwin Place, M.D., Midland  
Joseph H. Sherk, M.D., Midland
37. **Monroe**  
D. C. Denman, M.D., Monroe  
J. H. McMillin, M.D., Monroe
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E. N. D'Alcorn, M.D., Michigan Theatre Bldg.,  
Muskegon  
L. E. Holly, M.D., 876 N. Second St., Muskegon  
C. J. Durham, M.D., 868 N. Second St., Mus-  
kegon
39. **Newaygo**  
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W. H. Barnum, M.D., Fremont
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(Antrim, Charlevoix, Emmet and Cheboygan)  
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F. H. Lashmet, M.D., Petoskey
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mingham  
Palmer E. Sutton, M.D., Washington Square  
Bldg., Royal Oak  
Zea Aschenbrenner, M.D., Farmington  
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L. A. Farnham, M.D., W. Huron St., Pontiac  
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Bldg., Pontiac
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N. W. Heysett, M.D., Hart  
Walter Lemke, M.D., Shelby
43. **O.M.C.O.R.O. (Otsego-Montmorency-Craw-  
ford-Oscoda-Roscommon-Ogemaw)**  
C. R. Keyport, M.D., Grayling  
C. G. Clippert, M.D., Grayling
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E. J. Evans, M.D., Ontonagon  
C. C. Corkill, M.D., Ontonagon
45. **Ottawa**  
A. E. Stickley, M.D., Coopersville  
R. H. Nichols, M.D., Holland

46. Saginaw

Clarence E. Toshach, M.D., 333 S. Jefferson Ave., Saginaw  
L. C. Harvie, M.D., 405 Wiechmann Bldg., Saginaw  
W. K. Anderson, M.D., 316 S. Porter St., Saginaw  
S. A. Sheldon, M.D., 515 Building & Loan Bldg., Saginaw

47. Schoolcraft

James H. Fyvie, M.D., Manistique  
Albert R. Tucker, M.D., Manistique

48. Shiawassee

A. L. Arnold, Jr., M.D., Owosso  
C. M. Wilcox, M.D., Owosso

49. St. Clair

A. L. Callery, M.D., Peoples Bank Bldg., Port Huron  
T. E. DeGurse, M.D., Marine City

50. St. Joseph

R. A. Springer, M.D., Centreville  
None

51. Tuscola

T. E. Hoffman, M.D., Vassar  
W. P. Petrie, M.D., Caro

52. Washtenaw

John A. Wessinger, M.D., 339 E. Washington, Ann Arbor  
Dean W. Myers, M.D., St. Joseph Mercy Hospital, Ann Arbor  
L. J. Johnson, M.D., 225 E. Liberty, Ann Arbor  
F. B. Williamson, M.D., First National Bank Bldg., Ypsilanti  
John S. DeTar, M.D., Milan  
F. Bruce Fralick, M.D., University Hospital, Ann Arbor

53. Wayne

T. K. Gruber, M.D., Eloise Hospital, Eloise  
J. M. Robb, M.D., 641 David Whitney Bldg., Detroit  
C. E. Umphrey, M.D., 13331 Livernois Ave., Detroit  
Ralph H. Pino, M.D., 1001 David Whitney Bldg., Detroit  
E. D. Spalding, M.D., 662 Maccabees Bldg., Detroit  
R. M. McKean, M.D., 1515 David Whitney Bldg., Detroit  
H. W. Plaggemeyer, M.D., 1701 David Whitney Bldg., Detroit  
R. C. Andries, M.D., 1737 David Whitney Bldg., Detroit  
R. L. Novy, M.D., 662 Maccabees Bldg., Detroit  
Wm. R. Clinton, M.D., 113 Martin Place, Detroit  
A. E. Catherwood, M.D., 1337 David Whitney Bldg., Detroit  
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit  
Douglas Donald, M.D., 938 David Whitney Bldg., Detroit  
Grover C. Penberthy, M.D., 1515 David Whitney Bldg., Detroit  
Louis J. Hirschman, M.D., 7815 E. Jefferson Ave., Detroit  
R. C. Jamieson, M.D., 1551 Woodward Ave., Detroit  
Fred H. Cole, M.D., 1757 David Whitney Bldg., Detroit  
C. E. Simpson, M.D., 1210 Kales Bldg., Detroit  
C. S. Kennedy, M.D., 10 Peterboro St., Detroit  
H. F. Dibble, M.D., 1313 David Whitney Bldg., Detroit

Andrew P. Biddle, M.D., 638 David Whitney Bldg., Detroit  
C. E. Dutchess, M.D., c/o Parke, Davis & Co., Detroit  
Alexander W. Blain, M.D., 2201 E. Jefferson, Detroit  
Warren B. Cooksey, M.D., 60 W. Warren St., Detroit  
David I. Sugar, M.D., 7310 Grand River, Detroit  
Wm. J. Stapleton, Jr., M.D., 641 David Whitney Bldg., Detroit  
P. L. Ledwidge, M.D., 1818 David Whitney Bldg., Detroit  
C. E. Lemmon, M.D., 1337 David Whitney Bldg., Detroit  
J. A. Hookey, M.D., 655 Fisher Bldg., Detroit  
C. K. Hasley, M.D., David Whitney Bldg., Detroit  
C. F. Brunk, M.D., 7815 E. Jefferson, Detroit  
S. W. Insley, M.D., Maccabees Bldg., Detroit  
L. J. Bailey, M.D., 510 Professional Bldg., Detroit  
R. L. Laird, M.D., 513 David Whitney Bldg., Detroit  
Allan McDonald, M.D., 1340 Maccabees Bldg., Detroit  
C. F. Vale, M.D., 1306 David Whitney Bldg., Detroit  
E. R. Witwer, M.D., Harper Hospital, Detroit  
M. H. Hoffmann, M.D., Eloise Hospital, Eloise  
H. L. Clark, M.D., 634 Maccabees Bldg., Detroit  
F. W. Hartman, M.D., Henry Ford Hospital, Detroit  
Wm. S. Reveno, M.D., 951 Fisher Bldg., Detroit  
C. D. Benson, M.D., 1515 David Whitney Bldg., Detroit  
C. K. Valade, M.D., 1604 Eaton Tower, Detroit  
F. A. Weiser, M.D., 1502 David Whitney Bldg., Detroit  
J. A. Kasper, M.D., Herman Kiefer Hospital, Detroit  
G. L. McClellan, M.D., 1424 Maccabees Bldg., Detroit  
F. J. Kilroy, M.D., Receiving Hospital, Detroit  
S. E. Gould, M.D., 1432 Longfellow Ave., Detroit  
L. J. Gariepy, M.D., 16401 Grand River, Detroit  
C. S. Ratigan, M.D., 22340 Michigan St., Dearborn  
F. H. Purcell, M.D., 1808 Eaton Tower, Detroit  
L. O. Geib, M.D., 3528 Van Dyke, Detroit  
L. W. Shaffer, M.D., 1305 David Whitney Bldg., Detroit  
Wm. P. Woodworth, M.D., 2994 E. Grand River, Detroit  
H. W. Peirce, M.D., 1652 David Whitney Bldg., Detroit  
J. W. Hawkins, M.D., 4741 Spokane Ave., Detroit  
H. B. Fenech, M.D., 10 Peterboro St., Detroit  
H. L. Morris, M.D., 866 Fisher Bldg., Detroit  
N. K. H'Amada, M.D., 1018 Maccabees Bldg., Detroit  
Geo. Van Rhee, M.D., 10 Peterboro, Detroit  
W. B. Harm, M.D., 5884 W. Vernor Highway, Detroit  
B. H. Priborsky, M.D., 742 Maccabees Bldg., Detroit  
W. N. Braley, M.D., 12897 Woodward, Detroit  
Bernhard Friedlaender, M.D., 300 Rowena, Detroit  
\*W. L. Quennell, M.D., Highland Park General Hospital, Highland Park  
S. G. Meyers, M.D., 662 Maccabees Bldg., Detroit

54. Wexford-Kalkaska-Missaukee

W. Joe Smith, M.D., Cadillac  
John Gruber, M.D., Cadillac



## SUMMARY OF PROCEEDINGS OF THE HOUSE OF DELEGATES—1937

The Seventy-second Annual Meeting of the House of Delegates of the Michigan State Medical Society was held at Grand Rapids, September 27, 1937.  
The House of Delegates:

1. Accepted and adopted with thanks the reports of the Speaker of the House of Delegates (886\*), the President (886), the President-elect (886), and the Council (886 and 890-1-2), the Legislative Committee and its subcommittee on Group Hospitalization (887), the Joint Committee on Health Education (887), Medical Economics Committee (887), Cancer Committee (887), Preventive Medicine Committee and its subcommittee on Syphilis Control (887), the Post-Graduate Medical Education Committee (887 and 890), Public Relations Committee (888), Ethics Committee (888), Delegates to the A.M.A. (888), Maternal Health Committee (893), Contact Committee to Governmental Agencies (893), Mental Hygiene Committee (893), Radio Committee (893), Advisory Committee to Woman's Auxiliary (893), Liaison Committee with Hospital Association (893), Liaison Committee with Dentists, Nurses and Pharmacists (893), Joint Report of Committee Studying Schedules A, B, C, D and of the M.S.M.S.-M.H.A.-M.A.R. Committee (893).

2. Adopted an amendment to the Constitution (Art. 5) making the Speaker of the House of Delegates a member of The Council (894).

3. Adopted an amendment to the By-Laws (Chap. 6) substituting the title "Committee on Distribution of Medical Care" for the title "Committee on Medical Economics" (894).

4. Adopted an amendment to the By-Laws (Chap. 4, Sec. 1) relieving the President from the obligation of visiting all the county societies during his tenure of office (894).

5. Adopted an amendment to the By-Laws (Chap. 5, Sec. 2) defining the duties of the Councilor and including therein two visits per annum to each component society in his District (895).

6. Elected the following to Emeritus Membership (895); A. L. Arnold, Sr., Owosso; O. S. Armstrong, Detroit; W. R. Chittick, Detroit; D. W. Fenton, Reading; John Handy, Caro; Levi Harris, Gaylord; A. M. Hume, Owosso (886); J. C. Kugler, Jackson; R. J. Maas, Houghton; A. J. Roberts, Jackson; Edward Sawbridge, Stephenson; Wm. P. Scott, Houghton (895).

Elected to Retired Membership: Edwin J. Witt, Berrien County (895).

7. Ratified action of The Council in transferring Hillsdale from the Third to the Second Councilor District (879-880).

8. Presented scroll to L. G. Christian, M.D., in recognition of his services to Humanity and to Medicine (880-881).

9. Extended an invitation to the A.M.A. to meet in Detroit in 1939, 1940, or 1941 (886).

10. Accepted and adopted a resolution that the Legislative Committee use its influence to make physicians' and nurses' fees, for services rendered in the last illness, first class liens (896).

11. Accepted and adopted a resolution on improvement of morals as part of preventive medicine (896).

12. Accepted and adopted a resolution that the proper committee of the M.S.M.S. confer with all interested groups in order that there may be a proper understanding of the terms "hospital service" and "medical service" in Group Hospitalization plans (896).

13. Accepted and adopted a resolution urging that an inspector be secured for the State Board of Registration in Medicine whose duties shall be to investigate and make charges against violators of the Medical Practice Act (896-7).

14. Accepted and adopted a resolution re fees for medical information in insurance cases, as adopted by the M.S.M.S. in 1939 (897).

15. Accepted and adopted a resolution suggesting that the Michigan State Board of Registration of Nurses study the question of requirements for nurses' training schools and attempt to somewhat modify the present regulations (897-8).

### 16. Elected:

- (a) Henry A. Luce, M. D., Detroit, as president-elect (901)
- (b) Philip A. Riley, M.D., Jackson, as Speaker of the House of Delegates (901)
- (c) Martin H. Hoffmann, M.D., Eloise, as Vice-speaker of the House of Delegates (902)
- (d) T. F. Heavenrich, M.D., Port Huron, re-elected as Councilor of the Seventh District (898)
- (e) W. E. Barstow, M.D., St. Louis, re-elected as Councilor of the Eighth District (899)
- (f) E. F. Sladek, M.D., Traverse City, elected Councilor of the Ninth District (899)
- (g) P. R. Urmston, M.D., Bay City, re-elected Councilor of the Tenth District (899)
- (h) G. A. Sherman, M.D., Pontiac, elected Councilor of the Fifteenth District (899)
- (i) L. G. Christian, M.D., Lansing, elected Delegate to the A.M.A. (899-900)
- (j) G. J. Curry, M.D., Flint, re-elected Alternate Delegate to the A.M.A. (900)
- (k) R. H. Pino, M.D., Detroit, re-elected Alternate Delegate to the A.M.A. (900).

17. Referred to The Council the selection of place for the 1938 Annual Meeting (902).

18. Adopted a motion that a medal or charm be purchased for presentation to F. E. Reeder, M.D., Speaker of the House of Delegates for 1936 and 1937, in recognition of long service to the Society (901).

19. Thanked *The Detroit Free Press* for the Medical Supplement (901).

20. Thanked the Grand Rapid hosts and the press for hospitality and publicity (902).

\*Numbers refer to pages in the November, 1937, issue of THE JOURNAL of the Michigan State Medical Society.

## REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION, 1938

Because of the necessity of having this report in the hands of our State Secretary on July 1 that it may be included in our Hand Book for the September meeting it will be impossible to give a detailed report of the meeting at this time (June 27). Such a report necessitates a review of the proceedings of the House of Delegates and this will not be completely available until the July 2 edition of *The Journal*.

The eighty-ninth annual session of the American Medical Association was held in San Francisco, California, June 11 to 17, 1938. The attendance up to Friday morning, June 17, totaled 5,970 for the first four days. The Friday registrations will undoubtedly bring the total well over 6,000. Michigan maintained its attitude of loyalty by contributing 98 registrations, which is extremely good considering the time and expense entailed in making the trip.

Michigan again was honored in having two of its delegates appointed to important committee chairmanships. Dr. Henry A. Luce was appointed chairman of the Committee on Amendments to Constitution and By-Laws and Dr. J. D. Brook was appointed chairman of the Committee on Executive Session. While there were 172 delegates registered from forty-eight states, the Sections and various U. S. Possessions, it can be readily seen that two committee chairmanships constituted a lion's share of the available thirteen committees. As usual, and this is perhaps patting ourselves on the back, these two positions were handled by their respective chairmen with dignity, and all material referred was considered and reported with dispatch and directness, while maintaining conservatism and the interests of the doctor back home. Many compliments were received by the two committee chairmen on the character of their reports presented to the House.

Of the material considered by these two committees we submit the following from memory. (Subject to correction from official printed minutes.)

To the Committee on Amendments to Constitution and By-Laws, H. A. Luce, M.D., chairman, was presented the following:

Resolution from Michigan, sponsored by the Council of the State Medical Society and presented by Dr. T. R. K. Gruber, amending the By-laws to create a Public Relations Council of the A.M.A. This resolution and the address of Josephine Roche, read by Dr. W. F. Draper, and referred to the Committee on Executive Session, were the two "wasps' nests" of the meeting.

The last paragraph of the report presented by Dr. Luce expresses, in summary, the thought of the Committee and is presented herewith for your individual interpretation: "... to impress upon the Board of Trustees that careful consideration should be given to the operation of our agencies of public information so that on the one hand the necessary 'fortiter in re' may be preserved and on the other that certain deficiencies of 'suaviter in modo' may be corrected."

At the executive session, on Tuesday afternoon, the Committee on Executive Session placed its stamp of approval upon the report of the committee on contraceptive practices as found in the report of the Board of Trustees. It also recommended upon questions presented in a resolution by

Dr. Roberts of Georgia concerning the showing of the motion picture film entitled "The Birth of a Baby," that its showing be limited to adults and that whether or not it should be shown to the public was a matter for the various State and County Societies to decide, and recommended that it be so handled.

Upon the address of Miss Roche this same committee cited several inconsistencies in figures and questioned the accuracy of several of her statements and made no recommendations because of a pending joint meeting of organizations represented by Miss Roche, and representatives of the American Medical Association to be held some time during July. (See official proceedings of House of Delegates.)

At this executive session the House resolved itself into the Committee of the Whole for the purpose of considering a resolution sponsored by the New Jersey State Medical Society and introduced by one of its delegates, Dr. Snedecor, severely criticizing the activities of Dr. Morris Fishbein for the apparent personal advertising in a "health column" published in about 250 newspapers and for the glamorous newspaper advertising setting forth wonderful information values contained in a book edited by Dr. Fishbein. After presentation of the accusations by Dr. Snedecor, several House members, including the chairman of the Board of Trustees, spoke in defense of Dr. Fishbein. After the latter gave an explanation of the activities in question the resolution was tabled and Dr. Fishbein was given a unanimous vote of confidence.

In regular session, the House of Delegates voted to amend the association's "Ten Commandments" concerning socialized medicine to disapprove the inclusion of special medical services, such as pathological examination, x-ray work and anesthesia, in group hospital contracts and providing for removal of hospitals from association's approval list where either the public or profession is exploited.

The delegates reaffirmed that the House of Delegates is the only body qualified to speak for the American Medical profession and urged members affiliated with other medical societies to work for closer coöperation.

They vigorously opposed a Federal Department of Public Welfare as proposed in the recent reorganization bill and reiterated demands for a cabinet Department of Health with a medical man as secretary.

By action taken at the 1937 meeting, the assembly cities were selected for three years in advance as follows: St. Louis, 1939; New York City, 1940; Cleveland, 1941.

Dr. Rock Sleyster of Wisconsin was elected President, and Dr. H. H. Shoulders of Tennessee was elected Speaker.

For details as to whether this is a country of free speech, particularly as regards newspaper reporters, consult Dr. T. R. K. Gruber.

Subject to the approval of the delegates, additions to this report may be made at the time of the annual State meeting, following a perusal of the official proceedings.

Respectfully submitted,

J. D. BROOK, *Chairman*.

H. A. LUCE

T. R. K. GRUBER

C. R. KEYPORT

L. G. CHRISTIAN



## ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1937-38

Your Legislative Committee held four meetings during the past year, on November 10, 1937, February 27, March 30 and May 24, 1938. The first of the above was a joint meeting with the Executive Committee of The Council of the Michigan State Medical Society; the last was a joint meeting with the Policy Committee of the Wayne County Medical Society.

Pursuant to instructions of the House of Delegates, your Legislative Committee studied the possibility of making physicians' fees a first-class lien on estates. An extended survey of the legislation and activities in all the forty-eight states resulted in the conclusion that it would be inadvisable to seek such special privilege from the Legislature, but that the same desirable results could be procured by negotiations with the insurance companies doing business in Michigan. This work is now in process.

Your Legislative Committee respectfully reports that four members of the five-man Basic Science Board were appointed on May 6, 1938. The Attorney General has ruled that the Board as constituted can act legally, pending appointment of the fifth member by the Governor who has been waiting for the nomination of two full-time professors by the Michigan Chiropractic Society, which has not complied with the mandatory requirements of this law.

Your Committee studied the welfare reorganization, to be on the ballot of November 8, and is developing arguments pro and con for dissemination to the members of the Michigan State Medical Society.

Your Committee also studied recommendations re future legal and legislative activities of the State Society; a direct result was action by the State Health Department and the State Board of Registration in Medicine in assigning an inspector to work on violations of the Medical Practice Act. One inspector, however, is not sufficient to take care of the work; there is a need for a generous sum in the budget of the State Board of Registration in Medicine for several inspectors.

The Prenuptial Physical Examination Law was given further study, and various improvements were recommended to the Legislative Committee by the Advisory Committee on Syphilis Control.

The Uniform Narcotic Drug Act was considered, especially Section 3 to which objection was raised on the ground of double taxation on physicians.

The indiscriminate use of the title "Doctor" was surveyed, and the probability of a bill setting forth minimum educational requirements for the title "Dr." was discussed.

Group Hospitalization was studied, and referred to the Liaison Committee with Hospitals; the Medical Practice Act of 1899 was also considered and referred to the State Board of Registration in Medicine for necessary revamping.

The Michigan Health League was organized as a non-profit organization. This League, composed of physicians, dentists, nurses, pharmacists and laymen interested in health can do a great deal of good to protect the health laws of the State, to bring additional health information to the people, and to continue to build up confidence in the medical profession.

### Recommendations

1. Your Legislative Committee earnestly recommends that all members of the Michigan State Medical Society take an active interest in the development of the Michigan Health League which is designed to defend the health laws of the State of Michigan, outstanding for their progressiveness.

2. Your Legislative Committee invites attention

to the need for a definite sum in the budget of the State Board of Registration in Medicine, for inspectors, and respectfully urges the State Board to seek this necessary appropriation.

3. If the Welfare referendum is defeated, and the 1937 Welfare Laws are declared legal, your Legislative Committee recommends that the State Department of Public Assistance be contacted relative to the early establishment of a medical division, as authorized by Act 257 of the Public Acts of 1937, and that the State Society offer its advice and assistance in outlining the duties of the medical director thereof.

4. Your Legislative Committee repeats its recommendations of 1937 that no aggressive legislative program be planned for the 1939 session of the Legislature, in order that the position we now hold in the eyes of legislators, executive officers of the state, the press, and the general public, shall be maintained and strengthened.

The 1939 Legislative Committee of the Michigan State Medical Society will have to battle harder in order to combat bad legislation—it will have more to *stop*. We shall have to expect much cult legislation in 1939, and bitter attacks against the good health legislation now on the statute books of Michigan.

5. Finally, your Legislative Committee stresses the need for contact, before the 1938 election, with the legislator by his physician-constituents, i.e., his family physician, delegates to the Michigan State Medical Society, keymen in every county of the state, chairmen and members of county medical society policy and legislative committees—with officers of the county medical societies keeping up interest among their membership.

Respectfully submitted,  
L. G. CHRISTIAN, M.D., *Chairman*  
WM. H. HONOR, M.D.  
H. A. LUCE, M.D.  
G. L. McCLELLAN, M.D.  
A. R. MILLER, M.D.  
P. R. URMSTON, M.D.  
O. D. STRYKER, M.D.  
H. E. PERRY, M.D., *Advisor*  
J. B. BRADLEY, M.D., *Advisor*

## ANNUAL REPORT OF THE REPRESENTATIVES TO JOINT COMMITTEE ON HEALTH EDUCATION, 1937-38

The Joint Committee on Health Education has had a most productive year, in certain aspects the most productive year in its existence. Since the proceedings of the annual meeting held on June 3 have already been published in *THE JOURNAL*, your attention is directed to this report. At this meeting representatives from the majority of the twenty-seven member organizations were present, and Burton R. Corbus, M.D., of Grand Rapids, was re-elected chairman for the year 1938-39.

We would remind you that one of the most important functions of this committee is to serve as a coordinating unit through which adult and school health educational programs may be conducted. Three committees of the Michigan State Medical Society, during 1937-38, used the facilities of the Joint Committee. The Cancer and Syphilis Committees, each with programs designed to present authentic medical information to the laity, used the machinery of the Joint Committee in giving a total of 110 lectures before adult and professional groups, 72 on "Cancer" and 38 on "Syphilis."

The Radio Committee under the direction of Fred H. Cole, M.D., chairman, conducted a series of twenty-four weekly broadcasts on medical subjects



over eleven radio stations. Dr. Clare Gates, Field Secretary of the Joint Committee, obtained the co-operation of the radio stations, county medical societies and physicians who wrote the manuscripts, and was responsible for sending out the manuscripts weekly.

The Daily Health and Hygiene Column appearing in *The Detroit News* and ten other daily newspapers as well as many weekly newspapers, has been continued. Even though lectures and the radio programs are important channels for the dissemination of authentic medical information which concerns personal and community health, reaching the child through the schools is perhaps more important as a permanent and effective program. The responsibility of adequately instructing the child in matters of personal health and individual responsibility in order to reduce the hazards of preventable diseases, is not incumbent on any one professional or educational group. Desired results unquestionably can be accomplished with greater facility through a community of interest on the part of all interested participants. The Joint Committee can, and does, serve as a medium through which major interest groups may work without losing the identity of the participating unit. To develop a more effective means of instructing the children of Michigan in matters of health, has been a major activity of this past year. Through our sub-committee on School Health Education, instructional aids in the form of bulletins have been printed and distributed to school teachers. An active program to arouse school administrator and teacher interest in health education and to provide more adequate instruction in healthful living for persons who are training to become teachers, has been inaugurated. At the request of the State Department of Public Instruction, the bulletin "Mental, Personal and Social Hygiene," an interpretation of "Sex Education" has been prepared.

The activities of the Joint Committee, therefore, include a continuous program of adult health education and a long range program in school health education which will show less immediate results, but should pave the way for a more sound public conscience on matters of personal and community health.

Respectfully submitted,

BURTON R. CORBUS, M.D., *Chairman*  
M. S. CHAMBERS, M.D.  
L. FERNALD FOSTER, M.D.  
J. B. JACKSON, M.D.  
WM. S. REVENO, M.D.

## ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE, 1937-38

The Committee on Preventive Medicine held three meetings during the past year: on November 14, 1937, at the Hotel Olds, in Lansing; on January 9, 1938, at the Hotel Durant, in Flint; and on May 22, 1938, at the Statler Hotel, in Detroit. Various activities have been considered, namely:

### 1. Program on Preventive Medicine

A. *State Medical Meeting.*—The Committee approved the suggestion that it be recommended to the Program Committee of the Michigan State Medical Society that it devote one afternoon of the annual meeting to a symposium on Preventive Medicine, particularly Mental Hygiene, Tuberculosis, Cancer, Industrial Medicine, Syphilis, Maternal Health and Child Care, and Heart Affections. That each sub-committee present to the Program Committee the names of three speakers, one of whom shall represent

that committee on the program. Dr. Henry Cook also indicated his willingness to have the President's Night devoted to the subject of Preventive Medicine.

A second Annual Reunion Luncheon will be held at the meeting of the State Medical Society in Detroit, on which occasion, Dr. John Gordon of Boston, will be the speaker. His subject will be "Highlights of Rural Roumanian Medicine."

B. *Regional Conferences.*—The committee recommends that more consideration be given to the subject of Preventive Medicine in the programs at the Regional Conferences. It was agreed that at this time most stress should be on Tuberculosis, and it was suggested that a man be supplied by the Michigan Tuberculosis Association to sit in at the Regional Conferences. Syphilis, Pneumonia, and Cancer were to follow in order as subjects to be taken up at the Conferences.

C. *County Medical Societies* are also urged to devote more meetings annually to the discussion of some of the Preventive Medicine subjects, such as Toxoids, Vaccinations, Tuberculosis, Syphilis, Mental Hygiene, Cancer, Medical Education, Industrial Medicine, School Health, Maternal and Infant Care, and Heart Disease.

### 2. County Health Units

Again the Preventive Medicine Committee wishes to emphasize the advantages of the formation of County Health Units (not practicing units) in all counties, and that Federal funds are available for such purposes.

### 3. Medical Director

The Preventive Medicine Committee reiterates its request that funds be sought to employ a full-time medical health director, whose duties shall be to bring the advances in technic of the various tests to the physician in his own office, and with groups of physicians. He should also foster a better relationship between the physicians and the local health departments.

It was the consensus of opinion that the director or directors should work under a grant to the Michigan State Medical Society, but that under present conditions, the Michigan State Medical Society might delegate direction of their activity to the State Health Commissioner.

### 4. Immunization Schedule

The Preventive Medicine Committee approved the immunization schedule prepared by the Academy of Pediatrics.

### 5. Appointment of a New Sub-committee on Pneumonia

Approved.

### 6. Appointment of a New Sub-committee on Degenerative Diseases

Approved.

### 7. Report of the Sub-committee on Tuberculosis

Submitted by Dr. Bruce H. Douglas, chairman.

### 8. Report of the Advisory Committee on Syphilis

Submitted by Dr. L. W. Shafer, chairman. The Committee is indebted to Dr. J. D. Bruce, Vice President, University of Michigan; Dr. M.



R. Kinde, of the Kellogg Foundation; Dr. B. W. Carey, of the Children's Fund of Michigan; Mr. T. Werle, of the Michigan Tuberculosis Association, and Dr. Henry F. Vaughan, Commissioner of Health, City of Detroit, for their attendance at meetings, and for the counsel they have given.

Respectfully submitted,

L. O. GEIB, M.D., *Chairman*  
G. M. BYINGTON, M.D.  
A. L. CALLERY, M.D.  
B. H. DOUGLAS, M.D.  
R. B. HARKNESS, M.D.  
DON W. GUDAKUNST, M.D.  
EDGAR E. MARTMER, M.D.  
R. M. McKEAN, M.D.  
J. J. O'MEARA, M.D.  
H. H. RIECKER, M.D.  
C. C. SLEMONS, M.D.  
G. C. STUCKY, M.D.

### ANNUAL REPORT OF ADVISORY COMMITTEE ON SYPHILIS CONTROL 1937-38

#### Sub-committee of the Committee on Preventive Medicine

Meetings of this committee have been held during the last year as follows:

Pantlind Hotel, Grand Rapids, September 30, 1937  
Olds Hotel, Lansing, November 14, 1937  
Durant Hotel, Flint, January 9, 1938  
Statler Hotel, Detroit, May 22, 1938

At the first meeting in Grand Rapids the program for the year was laid out after discussion of the national program and the general principles of the Michigan program as reported in the previous annual report. The type and method of distribution of blanks for certification of applicants for marriage were discussed and approved. Dr. Shaffer was requested to prepare outlines of treatment for the various stages and clinical types of syphilis and present them for approval at the next meeting. The preparation of outlined talks illustrated with lantern slides was placed on the agenda for the next meeting.

At our meeting of November 14, 1937, the outlines of treatment as mentioned above were apportioning in THE JOURNAL of the Michigan State Medical Society. The Michigan State Health Department offered after some changes and recommended for ment offered to have them printed in pamphlet form and distributed with the free drugs for the treatment of syphilis which they stated would be ready for distribution about January 1, 1938. This offer was unanimously accepted and approved as an effective means of distribution. Drs. Breakey, Pleunc, Valade and Shaffer were ordered to prepare an "Outline of Reactions and Complications to Treatment with Technique." This was prepared and turned over to the State Health Department for printing and distribution along with the outlines of treatment. Drs. Bruce and Clare Gates, who were present, offered financial assistance in preparation of lantern slides for the professional and lay educational program. A special committee consisting of Drs. Breakey, Lavan, Valade and Shaffer was requested to prepare these outlines. A special meeting was called in Detroit for this purpose November 21, 1937.

At the meeting of January 9, 1938, the new regulations controlling reporting of venereal diseases were discussed including the new report form. It was admitted that these forms were complicated

but contained only necessary information and could be filled out in a minimum amount of time by simply checking the indicated answer. Fees for premarital examinations were discussed at length. It was admitted that the medical profession was under pressure from legislators to set a uniform fee for such examinations. If this is not done there is danger that such examinations may be ordered done by physicians on salary to the state. The plea was made by the committee that an endeavor be made to keep such fees on a minimum basis but at the same time they should be commensurate with the services rendered and expenses involved. The importance of holding patients with syphilis, particularly early cases to minimum standards of treatment was discussed. It was recommended that physicians put great emphasis on the initial interview, at which time the medical, social and legal aspects of syphilis be thoroughly and intimately discussed and understood. The problems of venereal disease in indigent patients was discussed and it was recommended that each county medical society contact its board of supervisors relative to payment of a fee to physicians for the care of indigent patients with venereal disease. The outline talks and illustrative slides selected for professional and lay education purposes were approved plus a diversified list of approved speakers. Any physician may be added to this speakers bureau on request when approved by his county medical society.

At our meeting held in Detroit May 22, 1938, the main item for discussion was changes for recommendation to our State Legislature in the present premarital physical examination law. It was recommended that where ever the word "venereal" appeared that the terms "syphilis, gonorrhea and chancroid" be substituted. It was likewise recommended that "accepted serologic test for syphilis" be substituted for "Kahn test" where specified in the law. Our most important recommendation was that in such cases where marriage would offer no danger of transmission of syphilis to the marital partner or offspring that a certificate to marry might be granted by the probate judge when approved by a committee appointed by the Commissioner of the Michigan State Health Department consisting of the physician of the person concerned, a medical expert, a representative of the health department and the probate judge. A second problem concerned recommendations on serologic interpretation to be printed on the reverse side of our state serologic report form was discussed at length. No definite action was taken except to recommend that each member of the committee write out his suggestions and send same to the chairman for summary and action at our next meeting. The problem of fees for premarital examinations was again discussed. We were unable to reach any definite conclusions except to suggest that all complaints made to the State Health Department be referred to our committee for our information and action.

We feel that many important measures have been instituted towards syphilis control in Michigan during the past year. Our program is however just getting under way and even more important problems still face us. Of these an even more aggressive program for postgraduate instruction must be arranged for the coming year. Approval is desired to refer cases to those physicians who have proven their interest and ability through special training and attendance at courses for postgraduate instruction. The problem of fees still faces us, both for premarital physical examinations and for routine treatment of indigent and borderline cases, especially those to be paid for by county or state or both. The question of recommending the total amount of treatment that should be paid for under such a set-up is a difficult one. We have still to formulate



our recommendations on serologic interpretation. These are only a few of the many problems facing us in the future.

Respectfully submitted,  
LOREN W. SHAFFER, M.D., *Chairman*  
ROBERT S. BREAKEY, M.D.  
R. S. DIXON, M.D.  
GEORGE HAYS, M.D.  
ROY H. HOLMES, M.D.  
WM. A. HYLAND, M.D.  
JOHN LAVAN, M.D.  
HAROLD R. ROEHM, M.D.  
C. K. VALADE, M.D.  
UDO J. WILE, M.D.

## ANNUAL REPORT OF ADVISORY COMMITTEE ON TUBERCULOSIS CONTROL, 1937-38

### Sub-committee of the Committee on Preventive Medicine

This Committee was organized for active work November 14, 1937, at which time Dr. Henry Cook, president of the State Medical Society, laid before the Committee some of the problems which he wished to see solved in connection with bringing together the practicing physicians of the state and the various voluntary and public health agencies interested in a tuberculosis control program. The coördination of the efforts of the various agencies, including the medical profession, in providing better facilities for case finding in tuberculosis was therefore accepted as the principal objective for the committee's work.

Several meetings have been held during the year with representatives of the State Health Department, Michigan Tuberculosis Association, and Michigan Association of Roentgenologists. Out of these conferences has come a much better understanding of the aims and objectives of the various groups and a splendid spirit of coöperation for the better handling of tuberculosis case finding.

The following definite projects have been undertaken:

1. Postgraduate instruction for physicians in the field of tuberculosis case finding has been arranged for the regional postgraduate conferences to be held at various centers this fall.

2. The Michigan Association of Roentgenologists has considered the matter of special attention to the problem of making x-ray services easily available in those communities where there are specialists in this field and have indicated that they are willing to make this service available for persons who can pay at very reasonable fees and for those who cannot, the work will be done for a much reduced fee when paid by a public health agency or some other interested organization.

The roentgenologists have definitely recognized the important place that the x-ray examination of the chest plays in any effort to find and diagnose tuberculosis.

The following recommendations have been made by the Committee and accepted by the Preventive Medicine Committee and The Council of the State Medical Society:

1. That tuberculosis case finding by tuberculin testing and the x-ray examination of positive reactors is recommended as a valuable procedure.

2. Examination of immediate family contacts to all known cases of tuberculosis as well as of those whose symptoms might suggest tuberculosis should be undertaken more extensively by all physicians.

3. That the reimbursement of the physician and the roentgenologist on a nominal fee basis when the patient cannot pay for the service is deemed essential.

4. That at the proper time funds be sought through the State Health Department for this purpose.

5. Pending the time when funds may be available to stimulate work on a state wide basis that attention be given to a few counties where the tuberculosis mortality and morbidity is high in the hope that provision for increased effort in case finding may be made in these areas.

6. And finally that local coöperation be sought throughout the whole state so that there will not be a duplication of effort by county sanatoria, county health units, tuberculosis societies, county medical societies and other agencies particularly interested in the fight against tuberculosis.

The work of this committee is just getting well under way and it is hoped that a committee of this sort may be continued for another year.

Respectfully submitted,  
BRUCE H. DOUGLAS, M.D., *Chairman*  
R. B. HARKNESS, M.D.  
GEORGE C. STUCKY, M.D.  
B. A. SHEPARD, M.D.  
E. R. WITWER, M.D.  
GEORGE SHERMAN, M.D.  
A. W. NEWITT, M.D.

## ANNUAL REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY OF THE STATE SOCIETY, 1937-38

The advisory committee of the Woman's Auxiliary to the Michigan State Medical Society has had two meetings this year, and the chairman has met with the Executive Committee of The Council and with Mrs. Hicks, president of the State Auxiliary, upon several occasions. A large amount of committee work has been conducted by correspondence.

At the beginning of the year the committee recommended the following activities:

1. Organization of a woman's auxiliary to each county medical society.
2. That each auxiliary member become civic minded; be a good club woman; and be a member of as many community groups as possible.
3. That she inform herself on state medicine in order to give the medical point of view.
4. That she become a member of the Michigan Health League.
5. That the woman's auxiliary assist the state medical society in its program on public health education; promote radio health programs sponsored by the medical society; and stimulate public interest in social hygiene, cancer education, tuberculosis, syphilis and maternal health.

The committee is pleased to report that the component units of the state auxiliary have as far as possible carried out these recommendations. Three new county auxiliaries have been organized—Newaygo, Lapeer and Washtenaw. Lay women's organizations throughout the state have shown a friendly attitude to the auxiliary which is an indication that members have become civic minded and are interested in community problems. There is no way to determine how much good has come from discussions on state medicine but it is believed that auxiliary members have informed themselves on this most vital question.

The auxiliary has assisted the state society in its program on public health education which is resulting in an increasing demand for medical speakers at lay meetings.

The Executive Committee of The Council directed the advisory committee to make a survey of the needs for a state benevolent fund. Questionnaires



were sent to every county society. Tabulation of the replies is as follows:

1. County societies in Michigan.....54
2. Number of replies.....43
3. Percentage of replies.....79%
4. Counties stating need for benevolent fund among physicians ..... 9
5. Counties stating need for benevolent fund in woman's auxiliaries ..... 3
6. Counties opposed to fund on basis it is not needed .....27

The results of this survey indicate that there is no need for a benevolent fund in Michigan. Most of the questionnaires made emphatic comments opposed to it. Two or three counties have a local benevolent fund which is administered in conjunction with the county medical society. It is difficult to understand that the need is so demanding as to warrant the maintaining of funds that might be used more advantageously for educational purposes in health programs.

At the last meeting of the committee the question of complete revision of the constitution and by-laws of the state auxiliary was discussed. It is recommended that an analysis be made and changes be considered as a major project during the coming year. It would seem that the constitution and by-laws of the state woman's auxiliary might be patterned after that of the state medical society. One of the suggested changes is for a smaller board of directors of seven members: president, president-elect, three past presidents, secretary and treasurer. A large board like the one at present consisting of the officers and chairmen of all committees is too unwieldy to function well.

The committee realizes the importance of a woman's auxiliary to the state medical society. The constantly changing social, economic and professional structure of our national government has created many controversial medical questions that must be intelligently explained to the laity. Women's organizations have always been valuable adjuncts to those of man. Today, more than ever before, man realizes the need of women's help in his government, his business and his profession.

The advisory committee wishes to pay a tribute to the woman's auxiliary for its unselfish interest and splendid coöperation in the mutual problems that have arisen during the year. The committee makes a personal appeal to the members of the Michigan State Medical Society that they become interested in the work of the auxiliary; that they attend the meetings to which they are invited; and that they cease to consider the woman's auxiliary as merely a social adjunct to their society.

Respectfully submitted,

HARRISON S. COLLISI, M.D., *Chairman*  
FLORENCE AMES, M.D.  
CLAIRE W. STRAITH, M.D.  
HAROLD W. WILEY, M.D.  
GORDON H. YEO, M.D.

## ANNUAL REPORT OF THE RADIO COMMITTEE, 1937-38

The second series of weekly broadcasts on medical subjects was conducted over eleven radio stations in the state. Starting in November and ending in April, twenty-four weekly programs were given through the coöperation of eleven county medical societies. It will be recalled that last year the Radio Committee called upon the several committees of the State Society to assume responsibility for the preparation of a designated number of radio scripts on subjects appropriate for the particular committee. This year, it was decided to ask some qualified physician to prepare each script. The subject titles

and the persons responsible for preparing the manuscripts are as follows:

- Ideals in Medicine.....W. J. Stapleton, Jr., M.D.  
First Aid to the Injured.....R. M. Bartlett, M.D.  
Colds and Their Complications.....W. H. Marshall, M.D.  
Means of Self-protection Against Cancer.....  
Henry J. Vanden Berg, M.D.  
\*Is It True in Dentistry?.....C. Wilford Wilson, D.D.S.  
Hearing.....Emil Amberg, M.D.  
Appendicitis.....C. D. Brooks, M.D.  
Discipline of the Child in the Light of Intra-family Relationships.....Louis A. Schwartz, M.D.  
Tuberculosis in the Child.....Bruce Douglas, M.D.  
\*Two Aids for Good Teeth.....K. R. Gibson, D.D.S.  
Pneumonias.....Hugo A. Freund, M.D.  
Surgery.....Charles G. Johnston, M.D.  
The Next Great Plague to Go.....Loren W. Shaffer, M.D.  
Heart Disease, Real and Imaginary.....Frank N. Wilson, M.D.  
\*Pyorrhea.....Clayton H. Gracey, D.D.S.  
Common Eye Troubles.....Ralph H. Pino, M.D.  
Maternal Health.....A. M. Campbell, M.D.  
Gonorrhea.....Robert S. Breakey, M.D.  
Anesthetics.....Henry K. Ransom, M.D.  
\*X-Ray's Place in Dentistry.....Ronald B. Fox, D.D.S.  
Asthma and Some Other Forms of Allergy.....  
Stanley W. Insley, M.D.  
Modern Weapons in the Fight Against Tuberculosis.....  
A.M.A. Script  
Safety Through Vaccine and Serums.....  
Edgar E. Martmer, M.D.  
Importance of Diagnosis.....A.M.A. Script

The Joint Committee on Health Education, through its field secretary, Clare Gates, assumed the responsibility of obtaining the coöperation of the country medical society, the radio stations and physicians who prepared the manuscripts. The participating medical societies and coöperating radio stations are listed below.

County Medical Society	City	Station	Time
Bay	Bay City	WBCM	12:30 P.M.
Calhoun	Battle Creek	WELL	6:30 P.M.
Genesee	Flint	WFDF	1:15 P.M.
**Houghton-Baraga-			
Keweenaw	Calumet	WHDF	6:45 P.M.
**Ingham	Lansing	WJIM	11:00 A.M.
Jackson	Jackson	WIBM	9:00 A.M.
Kalamazoo	Kalamazoo	WKZO	1:45 P.M.
Kent	Grand Rapids	WOOD	1:00 P.M.
Marquette-Alger	Marquette	WBEO	5:30 P.M.
Muskegon	Muskegon	WKBZ	11:00 A.M.
Wayne	Detroit	CKLW	7:45 P.M.

Time and facilities donated by radio stations approximate \$5,000, based on regular commercial rates. We call your special attention to the time of day that was allotted by the radio stations. No greater compliment could be given to an unsponsored (donated time) program by radio stations than that extended to us in giving voluntary time on the air during such favorable hours of the day.

The Committee feels deeply grateful for the unstinted coöperation of all those who have contributed their time and services toward making this program a success.

Respectfully submitted,

FRED H. COLE, M.D., *Chairman*  
ROBERT S. BREAKEY, M.D.  
F. M. DOYLE, M.D.  
C. D. HART, M.D.  
C. F. SNAPP, M.D.

\*The State Dental Society accepted the invitation to co-operate and contributed four talks. Local dentists read these talks on each occasion.

\*\*Coöperated this year but not last year.

# ANNUAL REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION, 1937-38

The registration in the courses in postgraduate medicine from July 1, 1937, to June 30, 1938, is as follows:

## Extramural Courses

Battle Creek-Kalamazoo .....	183
Bay City .....	154
Flint .....	132
Grand Rapids .....	173
Lansing-Jackson .....	170
Traverse City-Cadillac-Manistee-Petoskey.....	96
Marquette .....	39
Sault Ste. Marie-Ironwood, Marquette-Houghton-Escanaba .....	103
Grayling-Alpena-Petoskey-Traverse City.....	274
	1324

## Intramural Courses

Ann Arbor	
Electrocardiographic Diagnosis.....	33
Ophthalmology & Otolaryngology.....	65
Diseases of Metabolism.....	35
Diseases of Blood.....	29
Personal Courses .....	226
Detroit	
General Medicine .....	28
Pediatrics .....	29
Proctology .....	18
Urology .....	4
Obstetrics & Gynecology.....	16
	483
Total	1807

In the extramural course, 353 physicians attended from 50 to 100 per cent of the eight presentations.

The attendance from outside the State increased about 15 per cent over the preceding year.

A full report of the Committee's activities for the first half of the year was presented at the annual meeting of the Council in January, 1938, and reported in the March issue of THE JOURNAL, Michigan State Medical Society.

A meeting of the Postgraduate Committee was held at the Wayne County Medical Building, Detroit, at 2:15 P.M., April 20, 1938.

Present: Dr. R. B. Allen, Dr. H. H. Cummings, Dr. C. T. Ekelund, Dr. D. W. Gudakunst, Dr. G. C. Penberthy, Dr. F. E. Reeder, Dr. D. I. Sugar, Dr. Henry Cook, Dr. H. A. Luce, Dr. J. H. Dempster, Dr. P. R. Urmston, Dr. L. F. Foster, Secretary; Mr. Wm. J. Burns, Executive Secretary; Dr. James D. Bruce, Chairman.

Absent: Dr. A. P. Biddle, Dr. B. R. Corbus, Dr. W. B. Fillinger, Dr. G. A. Kamperman, Dr. R. R. Smith, Dr. C. C. Slemons.

The first item was the selection of subject matter for the extramural course for the coming year. Twenty-two subjects were considered and the following selected:

1. Fever of unknown origin.
2. The cardiac arrhythmias.
3. Diagnosis and treatment of the more persistent skin lesions.
4. The State's interest and responsibility in the problems of mental disease. The possibilities of cooperative action in the care of the mentally diseased.
5. Mental hygiene of the adult.
6. The doctor and the child.
7. Geriatrics. The care of the aged.
8. The indications for the use of certain drugs.
9. Peripheral vascular disease, including the care of varicosities and ulcers.
10. Intracranial and intraspinal injuries.
11. The Michigan Tuberculosis Association—a cooperative agency.
12. The physician and the tuberculosis problem.
13. The indications for surgery in tuberculous and non-tuberculous lesions.

14. The care of the infant at birth.
15. Preventive measures in infancy and childhood.
16. Pelvic inflammatory disease.
17. Management of hemorrhage in pregnancy.
18. Nephritis.

On account of numerous interruptions which have prevented a maximum of attendance during September and again in November, the Committee decided to divide the program between the spring and the autumn, selecting the months of October and April as probably of greater convenience to the profession. The subject matter for October, 1938, will be as follows:

1. Symposium on tuberculosis, its economic, social and clinical aspects.
2. Symposium on mental hygiene.
3. (a) Intracranial and intraspinal injuries.  
(b) Vascular disease of the extremities.
4. (a) Dermatology. Treatment of the more persistent skin lesions.  
(b) Management of diseases of old age.

Numerous communications have come to the Committee from time to time from physicians in the 14th district, who felt that the establishment of a more convenient center would stimulate attendance in that area. This was decided upon and on account of hospital accommodations and teaching facilities the University Hospital at Ann Arbor was selected for the coming year.

From time to time the profession of Saginaw has wished to share the extramural course with Bay City. The chairman of The Council visited the Saginaw profession, and a formal request was made that the 1938-39 program be given in Saginaw. As this seems satisfactory to both communities, the Advisory Committee has accepted the suggestion and the autumn course will be given in Saginaw.

From a number of communities has come the suggestion that a change of hours for the conferences would add to the convenience of the doctors, making possible a larger attendance. Accordingly, each community is being given the privilege of selecting the hours most acceptable to it. These changes of both location and hours will appear in THE JOURNAL as well as in the announcements.

It was brought out in the discussion that occasionally it has been difficult to provide a different teacher for each center and oftentimes on account of his special interests or fitness it has seemed desirable to employ one man for several or all centers. The Committee agreed that the number of speakers utilized should be governed by their fitness and availability.

Notwithstanding the many methods of notification which have been used by the Committee to inform the profession of the time and place of meetings, many doctors explain their failure to attend to lack of notice. The methods employed have been two or three preliminary notices of the general program in THE JOURNAL of the American Medical Association, and beginning early in the year and continuing throughout the period of the courses prominent notices have been given in THE JOURNAL of the Michigan State Medical Society. In addition to these, notices are sent to all members of the Society in advance of the first courses of the year, which usually begin in February, and another notice is sent in advance of the autumn courses. Press releases also are sent to all the larger newspapers of the State.

So that there be no possibility of inadequate notification, it was decided that the Executive Secretary send an additional notice to all members of the Society a few days in advance of the beginning of the autumn courses.

The question of the possibility of securing a con-



tinuation study center in Detroit under the University of Michigan, Wayne University, or both, through securing financial aid from Federal funds has been under discussion for some months. This possibility had been raised by Mr. Burns when he learned of the Minneapolis continuation center built by Federal funds, now operated by the University of Minnesota, and which contains living quarters for some seventy-five people as well as class rooms for the use of the various professional groups. Dean Allen of Wayne University Medical School expressed himself favorable to the idea but saw many difficulties in the assumption of responsibility by Wayne University or by a combination of Wayne and Michigan, and Dr. Bruce felt that the difficulties outlined by Dean Allen applied with equal force to the participation of the University of Michigan. However, acquiring a center of this character by either University, or through a combination of interests seems so desirable that it was felt the subject should continue to be explored by Executive Secretary Burns, Dean Allen and Dr. Bruce.

It will be recalled that in response to a request of several state societies, transmitted by the Massachusetts State Medical Society, for representation at a meeting called for the Atlantic City session of the American Medical Association in June, 1937, The Council requested the chairman of the Advisory Committee on Postgraduate Education to represent the Michigan State Medical Society. At this meeting, an accounting of which has already been given, the Associated Postgraduate Committee was organized and the chairman of the Michigan Advisory Committee on Postgraduate Education elected chairman. The chairman being unable to attend the San Francisco meeting on account of Commencement exercises at the University of Michigan, it was suggested that Dr. H. A. Luce or Dr. P. R. Urmston, who would be in attendance, present the address of the chairman. In communication with the other officers of the Associated Postgraduate Committee, it was felt that a regional chairman of the Committee would more appropriately preside and present the address of the chairman. Accordingly, Dr. Thomas P. Farmer of Syracuse, New York, represented Dr. Bruce.

It will be recalled that your chairman presented a supplemental report on postgraduate certification at the last annual meeting of the Society, and a form presented at this time was accepted tentatively. All records of attendance have been carefully reviewed and the registrants have been given opportunity to correct any possible errors. The list of those entitled to certification has been forwarded to the Executive Secretary and the certificates will be prepared and ready for distribution at the annual meeting of the Society, in accordance with the action of the House of Delegates.

It was felt by the Committee that postgraduate attendance should have two formal recognitions. First, an "Associate Fellowship in Postgraduate Education," designated by a certificate with the seal of the Society in silver, to be awarded on fulfillment of the first four-year attendance, or its equivalent; the second, a "Fellowship in Postgraduate Education," designated by a certificate with the seal of the Society in gold, to be awarded after a second period. It further provided that the subject matter of the four-year work may be concentrated in a period of one year for Associate Fellowship and over a two-year period for Fellowship.

A matter causing much concern to state examining boards, educators and the profession is that of the quite general inadequacy of the teaching of interns throughout the entire country. More and more the value of the present hospital provision for the intern is being questioned, and it would seem if the additional year required of the medical graduate is

justified that a more definite supervision should be contemplated and provided. In addition to the discussion at the last committee meeting, your chairman has discussed this matter with the National Committee on Graduate Education and with prominent physicians in different parts of the country. All are agreed that our obligation to the intern is not being fulfilled, and that the usual association with hospital staff members, no matter how friendly and interesting, is not a substitute for the more formal educational opportunities which this fifth year contemplated. As a first step in meeting this situation, it is suggested that a few hours once a month, preferably the latter part of the afternoon, be given over to a formal professional program, to be participated in by the interns and senior members of the profession. This has been discussed with the deans of both our medical schools, as well as a number of members of both faculties, and all are favorable to assuming this obligation. It is suggested that if undertaken the program be confined to a three-hour period, alternating once a month between Ann Arbor and Detroit for the first year, with a view of extending the periods and also later rotating the program in the various larger hospitals of the State.

There are a number of Committees of this Society that are definitely educational in character, and as such should bear a certain amount of responsibility in the formulation of postgraduate policies. While there has not been opportunity to discuss this matter with the Postgraduate Committee, your chairman at this time makes the suggestion that the chairmen of the following committees be included as members, or at least ex-officio members, of the Committee on Postgraduate Education: Cancer Committee, Preventive Medicine Committee, Maternal Health Committee, and Mental Hygiene Committee. The inclusion of the chairmen of these committees would, it is believed, materially strengthen the Committee on Postgraduate Education.

Respectfully submitted,

JAMES D. BRUCE, M.D., *Chairman*  
R. B. ALLEN, M.D.  
A. P. BIDDLE, M.D.  
B. R. CORBUS, M.D.  
H. H. CUMMINGS, M.D.  
C. T. EKLUND, M.D.  
W. B. FILLINGER, M.D.  
D. W. GUDAKUNST, M.D.  
G. A. KAMPERMAN, M.D.  
G. C. PENBERTHY, M.D.  
F. E. REEDER, M.D.  
C. C. SLEMONS, M.D.  
R. R. SMITH, M.D.  
D. I. SUGAR, M.D.  
T. G. YOEMANS, M.D.

#### ANNUAL REPORT OF THE COMMITTEE ON MATERNAL HEALTH, 1937-38

1. The Committee has been mostly concerned with completing the report of the Michigan Obstetric Study in the hope of having it in printed form for presentation at an early date. Because of other pressing duties devolving upon Dr. Carroll E. Palmer of the United States Public Health Service, the completion of the data has been delayed much beyond the expectation of the Committee. It is hoped, however, that a full report can be presented in pamphlet form at the annual meeting in Detroit.
2. The Committee has been interested in the release of the sound movie film, entitled, "The Birth of a Baby" and members of our Committee, after attending prevues of this film, were



unanimously in favor of its being released for public presentation. The Committee has heartily indorsed this film.

3. The Committee is happy to report that a Committee on Maternal Health is now appointed in every County Medical Society in the State, and that some of these Committees are extremely active in problems pertaining to Maternal Health in their communities. The State Committee has made certain recommendations to the Executive Committee of the Council with the purpose of activating these various Committees and acquainting them with their duties and opportunities in the field of Maternal Health.
4. The Committee indorsed a proposal made by Dr. J. D. Bruce and Dr. D. W. Gudakunst that a competent Obstetrician be appointed for approximately two months in the Upper Peninsula, to hold meetings and Clinics with Physicians, and be available for consultation. The Committee's approval of this proposal however, depends upon whether or not the majority of the physicians in the Northern Peninsula are in favor of this plan.
5. The Committee has gone on record in a former report concerning the scarcity of Obstetrical Clinical material at the University Hospital, and on June 7. of this year, it gave its unanimous approval of a plan suggested by Dr. Gudakunst, Health Commissioner of Michigan. This plan provides for a special appropriation of \$30,000, annually, to be used to help defray the expenses for additional clinical cases in the Obstetrical department in Ann Arbor.
6. The Committee has been interested in the type of Obstetrical Service furnished in the proprietary hospitals in the State which are licensed by the State Welfare Department, and one of the members of the Committee is making an investigation of this subject.

The Committee desires to acknowledge the excellent coöperation it has had from the United States Public Health Service and from the Executive Committee and from other officers of the Michigan State Medical Society during the year.

Respectfully submitted,

ALEXANDER M. CAMPBELL, M.D., *Chairman*  
 HAROLD A. FURLONG, M.D.  
 A. DALE KIRK, M.D.  
 NORMAN F. MILLER, M.D.  
 WARD F. SEELEY, M.D.  
 HAROLD W. WILEY, M.D.

#### ANNUAL REPORT OF CONTACT COMMITTEE TO GOVERNMENTAL AGENCIES, 1937-38

During the past year, your Committee held eight meetings, seven being in Lansing. In addition, the members made individual contacts with various governmental officials, agencies, and allied groups.

The principal matter referred to your Committee for study was amendments to the schedules under the Afflicted-Crippled Children Laws. Two meetings with the Michigan Crippled Children Commission, on February 15, and on March 2, were held. In addition, your Chairman was delegated to discuss necessary revisions in the schedules with the Auditor General of Michigan and with a representative of the Michigan Crippled Children Commission in Lansing on June 1. The result of this meeting was the final recognition of our radiologists and anesthesiologists as independent practitioners of medicine, with their fees inserted in Schedules A and C—an important principle for which these doctors of

medicine and the Michigan State Medical Society had been fighting for five years.

Another important subject referred to the Contact Committee was liaison work with the Governor's Medical Survey Committee. Three meetings were held with the Governor's Committee on March 2, May 4 and May 21.

Another problem referred to the Contact Committee was the investigation of medical care being accorded to employees of state institutions in lieu of salary, the service being given by physicians employed by the state to serve the inmates. A meeting on April 14 with Mr. Wm. Brownrigg, Personnel Director of the Civil Service Commission, was followed by meetings on June 22 with Doctor Joseph Barrett, Director, State Hospital Commission, and with Mr. Hilmer Gellein, Director of the Department of Corrections. A satisfactory understanding of the problem resulted from these contacts and discussions.

During the past year, your Committee met with a representative of the Michigan Department of Public Instruction to discuss school problems of the exceptional child. Technical advice was gladly given, and additional conferences on this matter are indicated.

Work of this committee is of extreme importance to the medical profession of the state. The Chairman has frequently, this year, been required to appear before various groups and address them, as well as to preside at sections, thereby showing that the medical profession of the state is interested in the problems of various other groups. Through these contacts much good will is built up for the profession. It also gives the medical profession a viewpoint just a little different from our own and keeps us abreast of the work and effort being put forward by various other agencies interested in health and allied activities. The Committee urges, therefore, that this work shall be carried on, ever exerting the influence of the profession where needed as well as developing an appreciation of the medical profession and of the fact that physicians really are interested in public problems.

HENRY COOK, M.D., *Chairman*  
 HENRY A. LUCE, M.D.  
 P. R. URMSTON, M.D.  
 WM. J. BURNS

#### ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE, 1937-38

The Committee on Mental Hygiene, recognizing the dangers in an unscientific approach to the subject of mental health and being thoroughly of the opinion that mental hygiene is a problem of health, has tried to lay the foundation of the committee's work on a real medical scientific basis.

With this end in view, early in the year the Committee decided that all material sponsored by the committee should be subjected to review by a selected number of the committee.

Your Committee would recommend to the Society that all publications on this or allied subjects in THE JOURNAL not sponsored by this committee be carefully reviewed by a competent board. It is becoming increasingly important that articles published in official journals of medical societies be carefully reviewed, because articles thus published have the appearance at least of being approved by the organization and thus accrue unwarranted standing.

Several articles in THE JOURNAL have been sponsored by the Committee and the Committee feels a pardonable pride in having arranged the details for an address by Dr. Winfred Overholser to the Public School Principals of Detroit and Public Health



Workers on April 27, 1938, at the auditorium of Wayne College of Medicine.

Your Committee again wishes to call to the attention of the membership the need for a continuing increase in postgraduate training as well as undergraduate teaching. Mental health has assumed such importance that your Committee feels that it would be derelict in its duty should it fail to attempt to arouse the profession to its responsibility for a thorough scientific understanding of the components of mental health.

Respectfully submitted,

H. A. LUCE, M.D., *Chairman*  
E. H. CAMPBELL, M.D.  
R. L. DIXON, M.D.  
M. H. HOFFMANN, M.D.  
R. C. MOEHLIG, M.D.  
R. A. MORTER, M.D.  
THEOPHILE RAPHAEL, M.D.  
R. L. SCHAEFER, M.D.  
R. W. WAGGONER, M.D.  
O. R. YODER, M.D.

### ANNUAL REPORT OF THE ETHICS COMMITTEE, 1937-38

The Ethics Committee of the Michigan State Medical Society wishes to offer its annual report to the House of Delegates.

The major complaint which this committee was called upon to study involved a general misunderstanding between two groups of doctors in central Michigan. The Ethics Committee ordered a hearing on the matter for all those concerned on Sunday, March 20, 1938 and we believe that the matter was adjusted with complete satisfaction to everybody. The defendant admitted that he had made a rather grave mistake and apologized for it in the presence of his accusers and the three members of the committee who were at the hearing. All of the records including the stenographic notes of both sides are now on file in the central office at Lansing.

There were a number of minor matters that were apparently adjusted by correspondence. We believe that the men are sticking closer together and hewing closer to the line of ethics than ever before—a very good sign in these days when the magazines are taking a full swing at the medical profession in general. We choose to submit our annual report without the mention of any specific names.

Respectfully submitted,

HORACE WRAY PORTER, M.D.,  
*Chairman*,  
L. C. HARVIE, M.D.  
EARL G. KRIEG, M.D.  
R. C. PERKINS, M.D.  
LEMOYNE SNYDER, M.D.

### REPORT OF MEDICO-LEGAL COMMITTEE, 1938

As requested by the Executive Committee of the Council we have prepared for the "Handbook of the Delegates" this partial report of the work of the Medico-Legal Committee. The regular report is made annually at the January meeting of The Council. This report is from January 1, 1938 to June 1, 1938. So much of the work is of such a confidential nature that it is thought unwise to publish the names in full. So far this year the following list gives briefly the new cases that have had papers served upon them. We have omitted names and addresses but outlined the reason very briefly. You

realize that there are always cases awaiting trial. Sometimes several years elapse before the cases actually get into court.

Dr. A.—Broken needle following injection of vaccine.

Dr. B.—Alleged malpractice in two operations.

Dr. C.—Suit because of alleged slandering.

Dr. D.—Suit just coming to trial after 1½ years. (fracture).

Dr. G.—Alleged poor results in gunshot wound.

Dr. G.—Alleged poor results following use of dinitrophenol.

Dr. H.—Burn resulting from use of cautery.

Dr. I.—Alleged malpractice following treatment of fracture.

Dr. J.—Alleged malpractice following treatment of fracture.

Dr. K.—Alleged malpractice following operation (repair).

Dr. K.—Alleged malpractice following hemorrhoids.

Dr. M.—Alleged malpractice following ulcers of leg.

Dr. M.—Alleged malpractice following confinement.

Dr. O.—Not a member. Alleged malpractice following removal of tonsils.

Dr. P.—Record not in yet. Suit.

Dr. R.—Alleged malpractice following circumcision.

Dr. T.—Alleged malpractice following burns.

Dr. T.—Alleged malpractice following fracture.

Dr. S.—Threat re burn following deep therapy.

Dr. W.—Suit re bad results following treatment of leg wound. Dues not paid.

Dr. Z.—Suit re bad results following treatment of fracture.

Right here we suggest that particular attention be paid to any case taken care of for the various welfare organizations, either city, county, state or national. Be sure your records are complete.

You will note the variety of reasons for the alleged malpractice. Five of the cases are fractures—here we stress again the use of x-ray before and after reduction and before discharge. Courts now hold that the exercise of ordinary skill and care requires the use of x-ray in diagnosis and treatment.

We would also call attention to the use of the various electrical and diathermy machines, hand lamps, et cetera. Burns resulting from the above are frequent causes for suits. We should bear in mind that the acts of the assistant or nurse using these under the doctor's direction makes the physician liable. We would also urge caution in the use of some of the newer and unaccepted drugs on the market. There are numerous cases in the courts regarding the use of dinitrophenol.

The matter of wrong diagnosis is another cause. It is well to have competent consultation in all doubtful cases.

We could go on and enumerate many other matters of interest to the doctor. In the past years our reports have pointed out various things to be avoided.

Malpractice is always with us. Many cases are just plain blackmail with no justification whatever. We feel that every doctor should be on his guard constantly so as to avoid any reason, real or alleged, for a malpractice suit. It behooves every one of us, general practitioner or specialist, to be very careful how we act toward people who come to us for treatment. Especially is this true when the patient complains about treatment received from another doctor. An unwise statement, the shrug of a shoulder or a skeptical tone may be the basis for a malpractice suit.

Again we suggest that doctors acquaint themselves with their rights and liabilities under the law. Remember, "Ignorance of the Law is no excuse." We suggest also that physicians read over the Harrison Narcotic Act. Be sure and register as required by law on the right date. The Commission is getting tired of doctors forgetting this important matter and there will be less leniency in the future. Don't forget also your registration under the new Michigan Narcotic Act.

The law, like medicine, never stands still. New laws are enacted constantly; new decisions are rendered daily in our Supreme Courts. So we of the medical profession should seek to keep abreast of the changes relating to medicine so that we may know the danger and thus keep from assuming unnecessary obligation. This Committee is your source of any legal information you may need.

Along the lines of preparedness we suggest the reading of the following books:

**Medical Relations under Workmen's Compensation.** American Medical Association, Price 65c postpaid. Such subjects as choice of physician, character of service rendered under various conditions, amount and forms of payment, and different methods of organizing the medical service were exhaustively considered and are covered in the report. The book is of vital interest to all physicians and surgeons having industrial connections. It is also a work that touches on problems of interest to all members of the medical profession.

**Medicolegal Cases. Abstracts of Court Decisions.** This volume will not make a physician his own lawyer, but will help avoid legal difficulties. Published by A.M.A., \$5.50.

**Courts and Doctors.** Stryker, The MacMillan Co., New York, \$2. An excellent little volume.

**The Doctor in Court.** Edward H. Williams, M.D. Williams & Wilkins Co., Baltimore, \$2.50. Fine for expert testimony.

**Perceval's Medical Ethics.** Lake. Williams & Wilkins Co., Baltimore, \$3. Every doctor should read this classic.

**Medical Jurisprudence.** Scheffel. Balkeston & Co. A good small volume for reference.

**Medical Ethics.** A rereading of the little red book published by the A.M.A. is worth while.

The Committee works as a sort of clearing house for all sorts of questions and is always ready to help in any way.

We respectfully submit this report for the consideration of the Delegates to the Annual Meeting. It is suggested that each Delegate make himself a committee of one to help stamp out the modern racket, "Malpractice."

ANGUS MCLEAN, M.D., *Chairman*,  
WM. J. STAPLETON, JR., M.D.,  
*Secretary*.

S. W. DONALDSON, M.D.

I. W. GREENE, M.D.

WM. R. TORGERSON, M.D.

## ANNUAL REPORT OF IODIZED SALT COMMITTEE, 1937-38

A sub-committee meeting of the Iodized Salt Committee was held February 23, 1938, at 12:30 noon at the Detroit Club, together with the committee from the Salt Manufacturers' Association represented by Mr. Morse, Secretary, and Mr. Ostrom, Advertising Manager of the Morton Salt Company, who came from Chicago on purpose for this meeting. Our sub-committee, listed to you before, was F. B. Miner, M.D., T. J. Cooley, M.D., David J. Levy, M.D., and Edgar Martmer, M.D.

A general program for educational purposes was discussed and many suggestions were made. It was decided that Mr. Ostrom would draw up a tentative program to be submitted to Dr. D. W. Gudakunst, State Health Commissioner, and Dr. Martmer for their approval, the final program to be sub-

mitted both to the Michigan Department of Health and the Iodized Salt Committee of the Michigan State Medical Society for their approval.

It was suggested that a member of the State Board of Education be invited to meet with Dr. Gudakunst, Mr. Ostrom and Dr. Martmer in preparing the program.

On May 7 the sub-committee reported, making recommendations for advertising propaganda. This has been considered by all the members of the Committee and is now in process of revision. In other words, we are not ready to give our approval to any educational propaganda that has been proposed up to the present time.

Respectfully submitted,  
D. MURRAY COWIE, M.D.,  
*Chairman*,  
THOMAS J. COOLEY, M.D.  
DAVID J. LEVY, M.D.  
EDGAR E. MARTMER, M.D.  
ROY D. MCCLURE, M.D.  
FRED B. MINER, M.D.

## ANNUAL REPORT OF LIAISON COMMITTEE WITH HOSPITAL ASSOCIATION, 1937-38

Your committee held three meetings during the past year, one on March 16, 1938 at the Wayne County Medical Society Building with representatives of the laity interested in the subject of group hospitalization, such as representatives of the Detroit Health Council, the Detroit Education Association, the Detroit Board of Commerce and the Detroit Council of Social Agencies; another at the Wayne County Medical Society on April 13, with representatives of the Michigan Hospital Association interested in the same subject; and the last on May 18, with the Executive Committee of The Council and officers of the Michigan State Medical Society, together with the Trustees of the Michigan Hospital Association.

In order to fulfill the instructions of the House of Delegates, which adopted a Resolution on this subject last year, your committee limited its formal work during the past twelve months to the study of group hospitalization. At its first meeting, it discussed two fundamental questions: (a) Should the medical profession be against any hospital service corporation in Michigan? and (b) if not, should any enabling act be general in scope, or contain details covering plans for group hospitalization?

Your committee felt that the medical profession ought to offer its advice in such an important matter as group hospitalization, in order that — — — should an enabling act be passed by the Legislature, it will have the ideas of the medical profession incorporated therein. (It will have the advantage of the medical profession's assistance in technical matters.) In answer to the second question, the Committee seemed to favor detailed statements in any law, and to that end developed preliminary recommendations for consideration by the medical society and the hospital association.

At the second meeting of your committee, these recommendations were discussed "as a plan for operation which may later form the basis of an agreement for enabling acts." The recommendations re group hospitalization as agreed upon in part by your Liaison Committee and a similar committee of the Michigan Hospital Association on April 13, 1938, follows:

"That hospital service or group hospital insurance, by whatever name called, shall include or exclude as hereinafter provided, the following:

"1. Hospital care if needed, up to a minimum of 21 days within each contract year, may be given on one or more ad-



missions; and shall include such other benefits as to number of days' care as may be found actuarially sound.

"2. The members shall be entitled to the following services in a participating hospital when such services are requested by his or her physician for in-patient care only, such per diem allowance and such bed accommodations as may be actuarially sound. The services included for the per diem allowance shall be (a) bed and board, (b) dietetic service, (c) operating room if actuarially possible, (d) surgical dressings and ordinary medications, (e) general nursing service, (f) interne and resident service where available, provided that resident service shall not be substituted for the services of a private physician, (g) emergency hospital care in any hospital anywhere up to a determined amount, (h) ambulance service in metropolitan areas as may be determined and upon the doctor's recommendation, (i) maternity cases including use of delivery room and nursing service not to be acceptable until after an agreed waiting period.

"3. Hospital care shall be construed to mean those services set forth in the paragraphs above and shall be given to members in accordance with the By-Laws of group hospital service or group hospital insurance as it may be incorporated, which are made a part of this contract; (a) the benefits offered by an agreement not to include the services of member's attending physician or surgeon, radiologist, pathologist,\* anesthetist,\* special nurses or their board; (b) hospital care for pulmonary tuberculosis (after diagnosis as such), venereal diseases, quarantinable diseases, alcoholic or drug addicts, mental disorders, or hospital care which is provided without cost to the members under the laws enacted by the legislature of any state, or the Congress of the United States (as for example, Workmen's Compensation Laws) are not included in the benefits offered by this agreement.

"4. Services under this agreement shall be rendered only upon the authorization and request of the member's physician, who must be acceptable to the selected hospital and be licensed to practice medicine in Michigan, or in the state where the emergency service is rendered. No right is conferred upon any hospital to select a physician or surgeon for the member.

"4A. Hospital care shall continue only during the time that the member is under the treatment and care of his or her physician in accordance with his staff privileges at such hospital, and will end at the time that the member is discharged as a hospital patient by his or her physician. The member will be responsible to the hospital for payment for services rendered in such hospital and which are not included in this agreement.

5.\* Any local or state-wide group hospital insurance under this plan that is organized in this state shall include on the Board of Directors an equal medical representation, this medical representation to be appointed by the local County Society or the State Medical Society.

"6. The rates, charges, and premiums to be charged the public for the hospital service and for the certificate therefor, and the certificates and benefits thereunder, herein provided for shall at all times be subject to the approval of the Superintendent of Insurance, and shall be adequate to meet the liability assumed under such contracts and all expenses incurred in connection therewith. †The Trustees of the Michigan Hospital Association in conjunction with the Executive Committee of The Council of the Michigan State Medical Society shall have the right, subject to the approval of the Superintendent of Insurance, to prescribe reasonable rules and regulations under and by which all certificate holders can procure the services herein provided for."

The above recommendations were discussed at length at the meeting of May 18, held in Eloise Hospital, with officials of both the medical society and the hospital association. No final determination was made regarding the items at issue in Sections Three and Five and Six.

The matter at the present time is on the table for further discussion at a future conference, by mutual agreement of those present at the meeting of May 18.

The House of Delegates of the American Medical Association has recommended that medical services be excluded from group hospitalization contracts. The medical profession is convinced that the inclusion of medical services "in kind" in group hospitalization contracts will have an undesirable effect on the practice of medical specialties in hospitals, and therefore on the quality of the services rendered. Two proposals have been suggested as a solution to the problem of medical services in group hospitalization contracts: (1) restrict the benefits

of the contract exclusively to the use of hospital facilities such as bed and board, operating room, medicines, surgical dressings and general nursing care; and (2) pay cash benefits directly to the insured for all medical services.

Your Committee has been attempting to follow the A.M.A. policy. It respectfully requests the House of Delegates of the Michigan State Medical Society to instruct it as to whether it shall continue on this course, or whether any changes or modifications are indicated at this time.

Respectfully submitted,

T. K. GRUBER, M.D., *Chairman*

G. J. CURRY, M.D.

I. W. GREENE, M.D.

REUBEN MAURITS, M.D.

PLINN MORSE, M.D.

E. R. WITWER, M. D.

## EXHIBITORS AT 1938 MICHIGAN STATE MEDICAL SOCIETY CONVENTION

Book-Cadillac Hotel, Detroit, September 20, 21, 22, 1938

Name of Company	City	Booth No.
Akron Truss Company.....	Detroit, Mich.....	75
A. S. Aloe Company.....	St. Louis, Mo.....	4
Arlington Chemical Company.....	Yonker, N. Y.....	15
Bard-Parker Company, Inc.....	Danbury, Conn.....	7
Bilhuber-Knoll Corporation.....	Jersey City, N. J.....	38
Burroughs Wellcome & Co. Inc.....	New York, N. Y.....	12
S. H. Camp Company.....	Jackson, Mich.....	22
Coca-Cola Company.....	Atlanta, Ga.....	70
Cottrell-Clarke, Inc.....	Detroit, Mich.....	64
R. B. Davis Sales Corp.....	Hoboken, N. J.....	66
Detroit X-ray Sales Corp.....	Detroit, Mich.....	59
Dictaphone Sales Corp.....	Detroit, Mich.....	71
Duke Laboratories, Inc.....	Long Island City, N. Y.....	52
Electray Equipment Company.....	Detroit, Mich.....	33
General Electric X-ray Corp.....	Chicago, Ill.....	53
Gerber Products Company.....	Fremont, Mich.....	45
Gordon Shoe Co.....	Detroit, Mich.....	72
Hack Shoe Company.....	Detroit, Mich.....	3
Hanovia Chemical & Mfg. Co.....	Newark, N. J.....	5, 6
J. F. Hartz Company.....	Detroit, Mich.....	54
H. J. Heinz Company.....	Pittsburgh, Pa.....	43
Holland-Rantos, Inc.....	New York, N. Y.....	36
Horlick's Malted Milk Corp.....	Racine, Wis.....	28
G. A. Ingram & Company.....	Detroit, Mich.....	62, 63
Jones Metabolism Equipment Co.....	Chicago, Ill.....	8
The Jones Surgical Supply Co.....	Cleveland, Ohio.....	56
A. Kuhlman & Company.....	Detroit, Mich.....	69
Lea & Febiger Company.....	Philadelphia, Pa.....	55
Lederle Laboratories.....	New York, N. Y.....	25
Libby, McNeill & Libby.....	Chicago, Ill.....	68
Liebel-Flarsheim Company.....	Cincinnati, Ohio.....	50
J. B. Lippincott Company.....	Philadelphia, Pa.....	9
M. & R. Dietetic Labs.....	Columbus, Ohio.....	47
Mead Johnson & Company.....	Evansville, Ind.....	29, 30
Medical Arts Pharmacy.....	Grand Rapids, Mich.....	26, 27
Medical Case History Bureau.....	New York, N. Y.....	40
Medical Protective Company.....	Wheaton, Ill.....	39
The Mennen Company.....	Newark, N. J.....	48
Merck & Company.....	Rahway, N. J.....	10, 11
The Wm. S. Merrell Company.....	Cincinnati, Ohio.....	46
C. V. Mosby Company.....	St. Louis, Mo.....	2
Nestle's Milk Products Co.....	New York, N. Y.....	16
Parke, Davis & Company.....	Detroit, Mich.....	17, 18, 19, 20
Pelton & Crane Company.....	Detroit, Mich.....	57, 58
Pet Milk Sales Corp.....	St. Louis, Mo.....	41, 42
Petrolagar Laboratories, Inc.....	Chicago, Ill.....	67
Philip Morris Company, Ltd.....	New York, N. Y.....	21
Physicians Equip. Exchange.....	Detroit, Mich.....	73
Picker X-ray Corporation.....	Chicago, Ill.....	23
Pocahontas Fuel Company.....	Detroit, Mich.....	74
Professional Management.....	Battle Creek, Mich.....	65
Randolph Surgical Supply Co.....	Detroit, Mich.....	13, 14
Sandoz Chemical Works, Inc.....	New York, N. Y.....	24
W. B. Saunders Company.....	Philadelphia, Pa.....	49
Smith, Kline & French Labs.....	Philadelphia, Pa.....	34, 35
E. R. Squibb & Sons.....	New York, N. Y.....	44
Frederick Stearns & Co.....	Detroit, Mich.....	60, 61
Van Hoosen Farm.....	Rochester, Mich.....	37
Vernor's Gingerale.....	Detroit, Mich.....	1
Wall Chemicals Company.....	Detroit, Mich.....	31
John Wyeth & Brother, Inc.....	Philadelphia, Pa.....	32
The Zemmer Company.....	Pittsburgh, Pa.....	51
Zimmer Manufacturing Co.....	Warsaw, Ind.....	76

Your patronage of these friends who are supporting the Michigan State Medical Society is earnestly recommended.

\*No determination made at meeting of April 13, 1938.

†The final sentence of Section 6 is to be re-drafted.

# President's Page

## HEALTH PROGRAMS REQUIRE JOINT EFFORT

AT THE recent meeting of the Michigan School Health Education Institute in Ann Arbor, I offered the following thoughts:

All people want health. But many do not know how to obtain it, and a good percentage who may know are not willing to make the effort to obtain it.

Never before has there been so great a general interest in the health of our people as now. Outside of the medical profession, voluntary health agencies, foundations and philanthropists, as well as writers and others are busily propagandizing Health. Some few are not willing to approach the problem fairly and honestly, do not recognize all sides of the question, or approach it with preconceived ideas. Fortunately, however, most realize the truth and are working from facts. Good results are being obtained, especially in the increase of public interest in the subject of health.

Coöperation with the medical profession in all these efforts always brings more beneficial results. Any health program requires confidence and joint effort between all parties concerned. There must be a thorough knowledge by persons or groups interested in a health program as to what are the aims and purposes of the project. Every fair effort must be put forward to place the program foremost in the objective; the whole plan must be executed on a strictly ethical basis.

The medical profession has always been willing to give its aid and advice in medical problems which have to do with health whenever they have been honestly sought. Those organizations successfully dealing with health today recognize this ethical need and are strictly adhering to it.

In a word, no health program is eminently successful when the medical viewpoint is ignored. On the other hand, more favorable returns are achieved when the technical advice and active assistance of the profession are sought and obtained.

Members of the Michigan State Medical Society: In line with these statements, I know you stand ready to render whole-hearted coöperation to any who are sincere in their efforts to make Michigan the most healthy commonwealth in the nation.

*Henry Cook*

President, Michigan State Medical Society.



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## EXECUTIVE COMMITTEE OF THE COUNCIL

May 18, 1938

### HIGHLIGHTS:

1. Group Hospitalization discussed with trustees of the Michigan Hospital Association.
2. Matters for presentation to the A.M.A. House of Delegates in San Francisco discussed with Michigan's Delegates to the A.M.A.
3. Letter to M.S.M.S. membership re: Supreme Court Amendment, sponsored by the State Bar of Michigan, given approval.
4. Proposed new building for the Army Medical Library and Museum in Washington, D. C., approved.
5. Personnel of the Basic Science Board, as appointed by the Governor, announced.
6. Woman's Auxiliary Annual Meeting Program, to be held in Detroit, September 20, 21, 22, approved.
7. Consolidation of Delta and Schoolcraft County Medical Societies recommended to M.S.M.S. House of Delegates.  
Elimination of one Councilor District (the present 13th District) recommended to the Council for presentation to the M.S.M.S. House of Delegates.
8. Revision of brochure "Who Wants Socialized or State Medicine!" given approval.
9. The August Meeting of the entire Council arranged.

1. *Roll Call*.—The meeting was called to order at 2:15 p. m. by Dr. P. R. Urmston, chairman, at Eloise Hospital, Eloise, Michigan.

2. *Minutes*.—The minutes of the meeting of April 14 were read and approved.

3. *Financial Report*.—The monthly financial report was presented. Dr. Moore suggested that future monthly reports show the relation of expenditures to the budget, and also a present worth statement of the bonds. Motion of Drs. Moore-Carstens that prior to the monthly meeting of the Executive Committee, the Committee on Bonds (Drs. Carstens, Hyland and Moore) be furnished a list of the bonds, to make a financial report on the condition of the assets at the meetings of the Executive Committee. Carried unanimously.

Motion of Drs. Carstens-Brunk that the bills, as presented, be paid. Carried unanimously.

4. *Committee Reports*.—(a) Medico-Legal Committee: The monthly report, presented in a letter from Dr. Stapleton, was read, accepted and ordered placed on file.

(b) Advisory Committee to Woman's Auxiliary report was presented in a letter from Dr. Collisi: no need for a Benevolent Fund at this time was indicated. Motion of Drs. Carstens-Moore that this portion of the report be accepted and placed on file. Carried unanimously. The budget of the Woman's Auxiliary for its convention in Detroit, September, 1938, was presented. Motion of Drs. Moore-Carstens that the sum of \$150 be allowed for this purpose. Carried unanimously. Program of the Woman's Auxiliary Convention in Detroit, September, 1938, was approved on motion of Drs. Carstens-Brunk and carried unanimously.

(c) Report of the meeting with Mr. Brownrigg of the Civil Service Dept. was given by Secretary Foster. Dr. Gruber stated that Eloise's employees do not receive medical care, in lieu of salaries. Motion of Drs. Carstens-Brunk that this be referred to the Contact Committee with Governmental Agencies. Carried unanimously.

(d) Postgraduate Medical Education Committee

report was given by Dr. Cook. Accepted and placed on file.

(e) Contact Committee with Governmental Agencies report was given by Dr. Cook. He outlined the activities of the Governor's Medical Survey Committee with meetings on May 4 and May 21.

The matter of news releases re the A.M.A. Survey was presented and discussed. Motion of Drs. Carstens-Moore that the Contact Committee to Governmental Agencies prepare appropriate releases, with the Executive Secretary. Carried unanimously. The report of the committee was accepted and placed on file.

(f) Committee of Radiologists on Attorney General's opinion: Dr. Moore presented this report, which was accepted and placed on file.

(g) Liaison Committee with Hospital's report was given by Dr. Gruber. A discussion ensued on group hospitalization.

Wayne S. Ramsey, M.D., Executive Secretary of the Crippled Children Commission, was introduced to the members of the Executive Committee, who welcomed him to Michigan.

5. *Annual Meeting*.—Dr. Foster gave a progress report on the annual meeting in Detroit next September. He recommended an Internes' Conference for Monday, September 19, which was approved.

6. *Upper Peninsula Secretaries' Conference*.—Dr. Foster reported on this Conference held in Marquette, May 15, and attended by Councilors Bandy and Manthei, Secretary Foster and Executive Secretary Burns, at which the A.M.A. Survey and other activities and problems were presented.

An invitation to send representatives to the June Conference of Health Officers at Mackinac was read. Motion of Drs. Riley-Moore that the Secretary and the Executive Secretary be authorized to attend this conference, as representatives of the M.S.M.S. Carried unanimously.

7. *Schoolcraft-Delta County Medical Societies Merger; also Elimination of the Councilor District*.—Secretary Foster presented the request of the two county medical societies for a merger. Motion of

Drs. Brunk-Moore that the Executive Committee of The Council recommend to the House of Delegates this consolidation, in accordance with the desires of the two county medical societies. Carried unanimously.

The Secretary also presented the request of the Alpena-Alcona-Presque Isle County Medical Society to be joined with the Tenth Councilor District (it is now in the 13th Councilor District); and also the request of the Northern Michigan County Medical Society (Antrim, Charlevoix, Cheboygan, Emmet counties) to be joined with the 9th Councilor District (it is now in the 13th Councilor District). This would eliminate the 13th Councilor District. The Secretary suggested that if the 13th Councilor District were abandoned, that the present 17th Councilor District (comprising the counties of Menominee, Dickinson, Iron, Gogebic, Ontonagon, Houghton-Keweenaw-Baraga) be re-numbered to District No. 13—permitting the Upper Peninsula to have Districts Nos. 12 and 13—and eliminating 17 as the number of a Councilor District. The state would then be divided into sixteen Councilor Districts. Motion of Drs. Carstens-Riley that the Executive Committee recommend to the Council, at its August meeting, that this matter be referred, as recommended, to the House of Delegates. Carried unanimously.

8. *August Meeting of The Council.*—Drs. Urnston and Foster invited the Councilors and the Officers to hold their August meeting at Point Lookout, north of Bay City. This could be arranged on a Sunday.

9. *Membership for Army, Navy, and U. S. Public Health Service Physicians.*—A letter from the Wayne County Medical Society relative to membership in the M.S.M.S. for these physicians was presented and discussed. The matter will be held until the next meeting of the Executive Committee.

10. *Brochure on "Who Wants Socialized or State Medicine?"*—The possible revision and dissemination of a revised brochure on this subject was presented by Secretary Foster and generally discussed. Motion of Drs. Carstens-Riley that the Public Relations Committee be authorized to prepare a revised brochure and present it and the cost for same at a future meeting of the Executive Committee. Carried unanimously.

11. *Spot Speakers Service.*—This suggestion was presented by Secretary Foster, as an end result of the A.M.A. Survey. The secretary was instructed to contact the Chairman of the Joint Committee and report at the next meeting of the Executive Committee.

12. *Instructions to A.M.A. Delegates.*—Matters for presentation at the San Francisco meeting of the A.M.A. were discussed by the Delegates and the Executive Committee of The Council.

13. *Request of State Bar of Michigan.*—The request of the State Bar for approval of a letter to be sent to all members of the M.S.M.S. re the Supreme Court Amendment was presented and thoroughly discussed. Motion of Drs. Moore-Brunk that the letter as corrected be sent out to the M.S.M.S. members on the Supreme Court Amendment Committee's stationery, and signed by Dr. Luce as a member of that committee. Carried unanimously.

14. *Army Medical Library and Museum, Washington, D.C.*—A letter from the A.M.A. relative to this proposed building was read. Motion of Drs. Carstens-Riley that the Secretary be directed to send letters to Michigan's senators and representatives to the U. S. Congress, recommending that adequate housing of the medical library be given consideration; and further, that all the county medical so-

cieties in Michigan be urged to take similar action. Motion carried.

15. *Basic Science Board.*—The Executive Secretary announced the appointment by the Governor of four of the five members of the Basic Science Board, as follows: W. O. Nelson, Wayne University, Detroit, pathology and anatomy; Fr. George Shiple, University of Detroit, chemistry; Ralph C. Huston, Michigan State College, physiology; J. P. Van Haitams, Calvin College, Grand Rapids.

16. *Birth Certificates.*—The matter of a few individual physicians failing to file birth certificates was presented and referred to the State Board of Registration in Medicine.

Recess: The meeting was recessed at 6:00 p. m. for dinner.

### Joint Meeting of Executive Committee of The Council and of the Liaison Committee with Hospitals, M.S.M.S. together with trustees of the Michigan Hospital Association

17. The meeting was called to order by Dr. Urnston, at 8:00 p. m. Present, in addition to those indicated above, were: Drs. J. Stewart Hamilton, E. R. Witwer, W. L. Babcock, W. G. Gamble, F. W. Hartman, Messrs. R. G. Greve, Ralph Huston, Wm. J. Griffith, Mr. Corneil, Miss J. Jackson, Mrs. George Wadley.

18. *Group Hospitalization.*—The Chair called upon Dr. Gruber to explain the activities of the Liaison Committee, and to present the recommendations of April 13. These were discussed, item by item. In Section 3, long discussion on the inclusion or exclusion of pathologists and anesthetists resulted in a motion by Dr. Gruber and Mr. Griffith that the matter be laid on the table for further discussion at a future conference. Motion carried 11 to 3.

19. *Thanks.*—A vote of thanks was placed on the minutes of the Executive Committee of The Council to Dr. Gruber for his hospitality in having this meeting at Eloise Hospital.

20. *Adjournment.*—The meeting was adjourned at 11:12 p. m.

### COUNCIL AND COMMITTEE MEETINGS

1. Wednesday, June 22, 1938—Representatives to Michigan Health League—Hotel Olds, Lansing—12:00 noon.
2. Wednesday, June 22, 1938—Contact Committee to Governmental Agencies—Lansing, 3:00 p. m.
3. Thursday, June 30, 1938—Executive Committee of The Council—Ann Arbor—6:00 p. m.

### STATE SOCIETY MEETINGS

"State Society Meetings" will be held in all of the County Medical Societies of the Upper Peninsula during August. Officers and Councilors of the State Society are making their annual tour. The tentative itinerary is as follows:

- August 8—Menominee
- August 9—Escanaba
- August 10—Iron Mountain
- August 11—Ironwood
- August 12—Ontonagon (noon)
- August 12—Houghton (night)
- August 16—Marquette
- August 17—Newberry
- August 18-19—Sault Ste. Marie (Annual Meeting of Upper Peninsula Medical Society)



# SOCIETY ACTIVITY

## SUPPLEMENTARY ROSTER

The following physicians, whose names did not appear in The Directory Number of THE JOURNAL, are members of the Michigan State Medical Society:

### Allegan County

Dolce, James A.....Allegan  
Horner, B. F.....Osego

### Bay-Arenac-Iosco-Gladwin Counties

Burton, Horace French....East Tawas

### Branch County

Chipman, E. M.....Quincy

### Calhoun County

Hansen, Harvey C.....Battle Creek  
Zinn, Karl.....Battle Creek

### Genesee County

Leach, J. L.....Flint  
Martin, Donald W.....Flint  
Rosenblum, H. G.....Flint  
Schiff, B. A.....Flint  
Winchester, W. H.....Flint

### Grand Traverse-Leelanau-Benzie Counties

Swanton, L. ....Traverse City

### Ionia-Montcalm Counties

Crunican, A. J.....Hubbardston  
Breece, Raymond .....Grand Rapids  
MacKenzie, Earl.....Detroit

### Kent County

Allen, R. V.....Grand Rapids  
Bell, Charles M.....Grand Rapids  
Bishop, T. P.....Grand Rapids  
Bolender, J. E.....Grand Rapids  
Breece, Raymond .....Grand Rapids  
DeYoung, T. ....Sparta  
Doran, Frank .....Grand Rapids  
Farber, Charles E.....Grand Rapids  
Faust, L. W.....Grand Rapids  
Fellows, K. E.....Grand Rapids  
Gibbs, F. F.....Grand Rapids  
Grant, Lucile R.....Grand Rapids  
Hilt, Lawrence .....Grand Rapids  
Hollander, Stephen.....Grand Rapids  
Hoogerhyde, Jack.....Grand Rapids  
Houghton, G. D.....Caledonia  
McBride, George L.....Grand Rapids  
Pott, A. L.....Grand Rapids  
Reus, Wm. F.....Jamestown  
Rodgers, Williams ....Grand Rapids  
Sculley, Ray E.....Grand Rapids  
Stover, Virgil E.....Grand Rapids  
Thompson, Archibald B., Grand Rapids  
Thompson, Athol B.....Grand Rapids  
Thompson, P. L.....Grand Rapids  
Tiffany, Joseph C.....Grand Rapids  
Winter, G. E.....Grand Rapids

### Midland County

Rice, Robert E.....Midland

### Ottawa County

Coburn, Milan.....Coopersville

### Saginaw County

Alger, G. L.....Saginaw

### Wayne County

Altshuler, Ira M.....Detroit  
Atchinson, Russell M.....Northville  
Atler, Lawrence R.....Detroit  
Bachman, Morris E.....Detroit  
Bergo, Howard L.....Detroit  
Besancon, John H.....Detroit  
Bevington, H. G.....Detroit  
Bower, Franklin T.....Detroit  
Braitman, Louis .....Detroit  
Bringard, Elmer .....Detroit  
Brown, A. O.....Detroit  
Burnstein, I. Marvin.....Detroit  
Bush, L. M.....Detroit  
Carey, Cornelius .....Detroit  
Carter, L. F. ....Detroit  
Clausen, Claire H.....Detroit  
\*Coolidge, Maria Belle.....Detroit  
Coseglia, Robert P.....Detroit  
Dixon, Fred W.....Detroit  
Donald, Douglas .....Detroit  
Durocher, E. J.....Ecorse  
Eades, Charles C.....Detroit  
Epstein, S. G. ....Detroit  
Erman, Joseph M.....Detroit  
Fellman, Abraham R.....Detroit  
Fenech, Harold B.....Detroit  
Freeman, Benjamin F.....Detroit  
Gage, David P.....Detroit  
Goldstone, R. R.....Detroit  
Gottschalk, F. W.....Detroit  
Grant, Lee E.....Detroit  
Greenberg, Morris Z.....Detroit  
Greenidge, Robert.....Detroit  
Grekin, Joseph .....Detroit  
Hall, James A. J.....Detroit  
Havers, Howard .....Detroit  
Henderson, L. T.....Detroit  
Hodges, Roy W.....Detroit  
Howard, Austin Z.....Detroit  
Howell, Bert F.....Detroit  
Howlett, Howard T.....Detroit  
Hubbard, Leighton R.....Detroit  
Jackson, Fred D.....Detroit  
Kennary, James M.....Detroit  
Kennedy, William Y.....Detroit  
Kowalski, Valentine L.....Detroit  
Lawrence, Wm. C.....Detroit  
Leaver, L. Ross .....Detroit  
Lee, H. E.....Detroit  
Levitt, Edward J.....Detroit  
Lynn, David H.....Detroit  
MacKenzie, Earl .....Detroit  
MacKenzie, R. D.....Detroit  
Markoe, R. C. L.....Detroit  
Martin, R. M.....Detroit  
Mateer, John G.....Detroit  
McClellan, R. J.....Detroit  
McClendon, James J.....Detroit  
McLaughlin, Nelson.....Detroit  
McLean, Harold G.....Detroit  
McQuiggan, Paul.....Detroit  
Moloney, J. Clark.....Detroit  
Morand, L. J.....Detroit  
Moriarty, George .....Detroit  
Novy, R. L.....Detroit  
Plaggemeyer, H. W.....Detroit  
Rexford, Walton K.....Detroit  
Robertson, S. B.....Detroit  
Robertson, T. H.....Detroit  
Sandler, Nathaniel.....Eloise  
Schillinger, H. K.....Detroit  
Scott, Robert J.....Detroit  
Shawan, H. K.....Detroit  
Skully, E. J.....Detroit  
Smith, James A.....Detroit  
Spero, Gerald D.....Detroit  
Steiner, Max .....Detroit  
Stern, E. A. ....Detroit  
Sullivan, H. A.....Detroit  
Tassie, Ralph N.....Detroit  
Tenaglia, Thomas A.....Ecorse  
Thomas, J. T., Jr.....Detroit  
Tryon, Mary .....Detroit  
Turbett, S. O.....Detroit  
Valade, C. K.....Detroit  
Walker, J. Paul.....Detroit  
Watson, Robert W.....Highland Park  
Wellard, Henry O.....Detroit  
Wilson, F. S.....Detroit  
Young, James P.....Detroit

\*Dr. Coolidge was erroneously listed in the M.S.M.S. Roster in the Directory Number under Grosse Pointe. Her name should have been listed with the physicians in Detroit.

## COUNTY SOCIETIES

### ALLEGAN COUNTY

W. M. German, M.D., Grand Rapids, addressed the members and their ladies and the local dentists and their ladies on June 7 at Allegan. Doctor German gave a very entertaining and instructive travelogue through Mexico. The guests were entertained during dinner by fine orchestra music. All members were present except two; the total attendance was sixty-two. Two new members were accepted, James A. Dolce, M.D., of Allegan, and B. F. Horner, M.D., of Otsego.—M. B. BECKETT, M.D., *Secretary*

\* \* \*

### BERRIEN-CASS COUNTY

"Medical Practice in Persia" was the subject of an interesting talk given by Harry Drinkman, M.D., of Ann Arbor, at the June 16 meeting held at Shady Shores, Dewey Lake. Doctor Drinkman is a former missionary to Persia where he spent four years. He discussed his experiences there and told of some of the problems with which a physician is called upon to cope.

A. F. BLIESMER, M.D., *Secretary*

\* \* \*

### CALHOUN COUNTY

John A. Alexander, M.D., Ann Arbor was guest speaker at the meeting of June 7 held at the Marywood County Club, Battle Creek. His subject was "Pulmonary Complications, Bronchiectasis, Lung Abscess." The meeting was preceded by a golf tournament at 3:00 p. m. A demonstration of Obstetric Coöperative Service Equipment was given by nurses from the Kellogg Foundation.

WILFRID HAUGHEY, M.D., *Secretary*

\* \* \*

### EATON COUNTY

Election of officers was held at the June 16 meeting in Charlotte at the Carnes Tavern. The newly elected officers are President, Bert Van Ark, M.D., Eaton Rapids; Secretary, T. Wilensky, M.D., Eaton Rapids.

This is our last meeting until next fall.

THOMAS WILENSKY, M.D., *Secretary*

\* \* \*

### IONIA-MONTCALM COUNTY

The meeting of June 16 was held at the Michigan Department of Health Laboratories near Lansing, Dr. C. C. Young being host. Members of the Society met at the Laboratories at 2:30 p. m. and the Laboratory Staff demonstrated many of its activities which proved exceedingly interesting. A program was arranged for after dinner.

JOHN J. MCCANN, M.D., *Secretary*

\* \* \*

### MONROE COUNTY

Warren Babcock, M.D., Detroit, spoke to the members of the Medical Society and the Woman's Auxiliary in Monroe on February 17. His subject was "Medical Fads and Fantasies." About sixty people were present.

John Sheldon, M.D., of the University Hospital, Ann Arbor, gave a paper on "The Diagnosis and Treatment of Asthma" at the meeting of April 21.

"State Society Night" was held on May 19 at the Monroe Country Club. Guests of the Society were H. H. Cummings, M.D., Ann Arbor, Councilor of the 14th District; Paul R. Urmston, M.D., Bay City; L. Fernald Foster, M.D., Bay City, and Wm. J. Burns of Lansing. The A.M.A. Survey was discussed and President Gelhaus appointed the following as a committee in charge of the survey in Mon-

roe County: A. H. Reisig, M.D., L. C. Blakey, M.D., and E. C. Long, M.D.

FLORENCE AMES, M.D., *Secretary*

\* \* \*

### MUSKEGON COUNTY

Harold Morris, M.D., Detroit, spoke to the Society at its meeting of June 17 on the subject of "Pyelitis of Pregnancy." The meeting was held at the Occidental Hotel.

L. E. HOLLY, M.D., *Secretary*

\* \* \*

### OAKLAND COUNTY

Officers of the State Society were guests at the meeting of July 13, held at Orchard Lake Country Club. Mr. Wm. J. Norton of the Michigan Children's Fund and of the State Welfare Commission discussed the Welfare Reorganization Bill which will come before the voters of the state in November.

O.O. BECK, M.D., *Secretary*

\* \* \*

### ST. CLAIR COUNTY

A fish dinner and special business meeting of the society was held at the Hotel Harrington, Port Huron, on May 31.

J. H. BURLEY, M.D., *Secretary*

## CORRESPONDENCE

The Editor, JOURNAL of the Michigan State Medical Society

At the opening session of the American Medical Association convention in San Francisco on June 12, the delegates attended a preview of "Men of Medicine: 1938," a twenty-minute MARCH OF TIME film narrative on medical science's immeasurable contribution to American life. Immediately thereafter, it was released to 11,374 theatres throughout the world and will be seen by an estimated U. S. audience of 24,000,000 people.

This is the first authentic motion picture for theatrical distribution produced with the unrestricted cooperation of the American Medical Association, the U. S. Public Health Service, and the medical departments of the U. S. Army and Navy. Already those doctors who have seen the picture in our projection room have been unanimous in their praise and approval not only of the picture's accuracy but of its potential value in bringing essential medical knowledge to the public.

No film before has told the story of the 69 great medical schools of the U. S., the 10 years of training which each doctor must undergo at a cost of nearly \$15,000, the fact that U. S. doctors, in a time of depression, are today contributing \$1,000,000 daily in free clinical services for the poor and distressed.

Coming at a time when actually 40,000 or more American doctors earn less than \$2,000 annually, when new plans for coöperative medicine, group hospitalization, health and old age insurance and government aid are discussed on every hand, this important record of the practice of medicine, ranging from the duties of the small-town country doctor to great laboratories of internationally-known institutions, constitutes not only an important document of medical progress but an informative and educational record which every layman should see.

Sincerely yours,

LOUIS DE ROCHEMONT,  
Producer and Publisher,  
The March of Time.

June 9, 1938



## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### Jackson County

The Woman's Auxiliary held their closing meeting for the season Tuesday evening, May 17, at the Hotel Hayes. A seven o'clock dinner was served, the members being alphabetically seated. The tables were beautifully decorated with seasonable flowers, iris and spirea predominating. Mrs. J. H. Myers, historian, read a very interesting report of the year's work. Mrs. W. H. Enders, project chairman, announced that the re-decorating of one ward room at each of Foote and Mercy Hospitals had been completed and the committee was now getting rockers for the nursery at Foote Hospital. Mrs. John Ludwick, retiring president, made note of the fact that the Auxiliary now has a membership of seventy and she hoped that Mrs. Alter, the new president, would be successful in increasing the membership to seventy-five next year, which would make it 100 per cent.

The dinner was followed by a social hour, bridge being played by most of the members.

The committee for arrangements were Mesdames John Smith, chairman, Harold Hurley, Hector Chabut, George Baker, M. D. Wertenberger, Edward Crowley and David Phillips.

ANNA HYDE SHAEFFER  
*Publicity Chairman*

### Kalamazoo County

The annual meeting of the Woman's Auxiliary was held at the home of Mrs. L. H. DeWitt on May 17.

Covers were placed for thirty-nine members and twenty-nine guests at dinner.

After the annual reports of officers and committee chairmen the following officers for next year were elected: President, Mrs. F. M. Doyle; President-elect, Mrs. R. G. Cook; Vice President, Mrs. Sherman Gregg; Secretary, Mrs. L. J. Crum; and Treasurer, Mrs. W. D. Irwin. Mrs. W. W. Lang and Mrs. F. M. Doyle were named delegates to the state convention.

Two new members were welcomed.

The later evening was spent informally.

Members of the Auxiliary and the Academy were guests of Mr. Heavey of the State Theater on May 19 at a preview of the film, *The Birth of a Baby*.

(MRS. HUGO) BARBARA K. AACH,  
*Publicity Chairman*

### Kent County

The Auxiliary had its annual luncheon at the Woman's City Club in Grand Rapids May 12. Mrs. Carl Snapp, the retiring president, presided. Dr. H. S. Collisi, chairman of the state advisory committee to the state auxiliary, was an honor guest and speaker. He outlined some specific ways in which the auxiliaries could be more effective.

There followed reports from the officers and committee chairmen. The group was particularly happy to know that the benevolent fund had been increased this year by \$278.09. The membership chairman reported 138 paid members. Ninety-one of these subscribed to *Hygeia*.

The auxiliary expressed its thanks and apprecia-

tion to Mrs. Snapp for her leadership and devotion this year.

Mrs. Henry Pyle, chairman of the nominating committee, presented the slate of nominations and new officers and committee heads as follows were elected:

President.....Mrs. Wm. Butler  
Vice President.....Mrs. J. B. Whinery  
Secretary.....Mrs. Robert M. Eaton  
Treasurer.....Mrs. Harold Robinson  
Corresponding Secretary.....Mrs. Lucian Griffith  
President-Elect.....Mrs. Lynn Ferguson

#### Committee Heads

Program.....Mrs. Leon De Vel  
Membership.....Mrs. R. G. Laird  
Social.....Mrs. H. S. Collisi  
Hygeia.....Mrs. Guy De Boer  
Press.....Mrs. Charles Frantz  
Courtesy.....Mrs. Leon Bosch  
Legislative.....Mrs. L. M. McKinlay  
Public Relations.....Mrs. Fred P. Currier  
Philanthropic and Welfare.....Mrs. J. C. Tiffany  
Revision.....Mrs. Henry J. Pyle  
House.....Mrs. A. J. Baker  
Historian.....Mrs. A. V. Wenger

(MRS. ROBERT M.) MIRIAM ADAMS EATON,  
*Press Chairman.*

### Monroe County

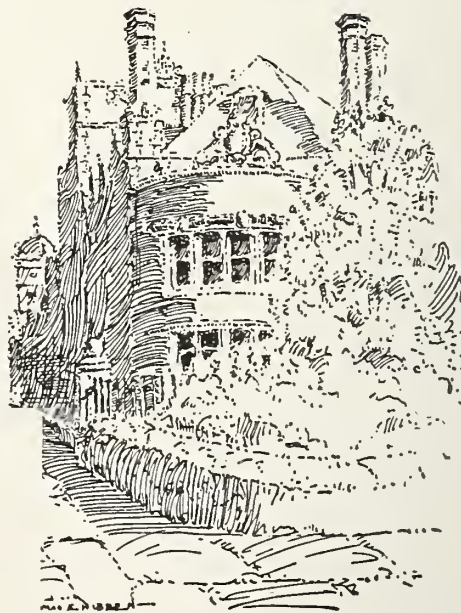
The Auxiliary had its April meeting a buffet supper, in honor of the state president-elect, Mrs. P. R. Urmston. Mrs. W. W. Bond, our local president-elect, was hostess, and twenty-five guests were present. Mrs. L. F. Foster, a member of the Bay City Auxiliary, was also a special guest.

(MRS. VINCENT) MARTHA BARKER

### Tuscola County

A new Auxiliary was organized on May 12 with eleven members, and plans for next year were discussed with enthusiasm. A joint meeting with the Tuscola County Medical Society will be held in June.

MRS. L. C. SAVAGE, *Secretary.*





## *For a Glorious Vacation*

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A. S. KIRKEBY, *Managing Director*

## **The Drake**

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SAFE—STERILE—HOME DELIVERIES

WITH THE NEW DISPOSABLE

INGA - **OB** - KITS

This kit affords the physician a SAFE, sterile field for his home deliveries. It is SIMPLE, COMPACT and EFFICIENT. A thermo-aseptic indicator assures its sterility. Remember—specify the INGA O.B. KIT.

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WAUKESHA SPRINGS SANITARIUM

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For the Care and Treatment of  
Nervous Diseases

Building Absolutely Fireproof

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FLOYD W. APLIN, M. D.  
WAUKESHA, WIS.

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Aschheim-Zondek Pregnancy Test

Intravenous Therapy with rest rooms for Patients.

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The pathologist in direction is recognized  
by the Council on Medical Education  
and Hospitals of the A. M. A.

## MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

### THE DEPARTMENT OF HEALTH AND HEALTH EDUCATION

The transition of the health department program during the past three or four decades from one of environmental sanitation, quarantine and law enforcement to its present broad educational scope has come about through the realization that the health of the people depends not solely upon what has been done for or to them, but principally upon what people do for themselves, declared Dr. Don W. Gudakunst, State Health Commissioner, in addressing the recent School Health Education Institute at Ann Arbor.

This transition has not been an easy one to make, for people could not readily give up their concept of actual or implied threat at the mention of a board of health. Then, too, this new educational program was met by the challenge that each of us is inclined to think we are natural-born teachers—that we are competent to enter the field of health education. Yet a survey of persons engaged in health education today indicates that they are drawn from all walks of life save that of education.

Teaching as a profession is a science and an art. An educational task is no less difficult because we define it by the modifying term "health education." Our difficulties are only increased by this specialization. There is nothing in the prescribed academic training of physician, nurse or engineer that gives that person any insight in the learning processes of people, nor does such training afford any mastery over the methods to be utilized in teaching.

I have listened to school doctors talk to parents. They were more prone to order than to teach. I have heard sanitary inspectors attempt to gain their point by insisting the public "must" because it was the law. I have heard health officer after health officer defend this as education and claim this was part and parcel of a health education program. We must be certain, therefore, that the members of our staff have some knowledge of and abilities in teaching before they undertake the rôle of educator.

We have long felt the need for this type of educational health program, but we have not been able to do any too much about it. There are, however, several points which can be considered by any health department in conducting its health education program. Answers to the following questions are fundamental: 1. What needs to be taught? 2. Who needs to be taught? 3. Can those selected learn the lesson we attempt to teach and can they alter their behavior if they do learn? 4. How can they learn and what are their learning processes? 5. Who can best teach this lesson? and 6. How should it be taught?

We must first find what is our greatest need that can be met. This need in most instances is, of course, not universal. Not all people need to be taught all the points of health. Health education must be selective, directed and purposeful.

Next we must consider whether the unhealthy situation can be remedied by education. With many of the diseases we are totally at a loss, for we have no real remedy. For example, we have been teaching the prevention of colds. To the best of our knowledge there is no prevention. There is no

decrease in incidence as the result of talking. Our desires outpace our abilities to control.

Our programs of health education must be directed to those who need education; they must be pertinent in point of place, time and subject matter. Then next we must consider the very important fact as to whether our educational endeavors can result in altered human behavior. If we cannot see our way clear to carry an educational program through to the point of altering behavior, then it is better never to start in the first place.

How should we teach health? I am only too free to admit I do not know. That we must teach is admitted by all—this is the salvation of public health. Our very existence depends upon our abilities as teachers. We are learning, but slowly. Only a beginning has been made, and much that is wrong has been done; much, too, that is good. But we have not given sufficient thought to why it was good or why it was wrong. My plea is to study ourselves. Let us be most critical. Let us learn first before we attempt to teach.

\* \* \*

#### PUBLIC HEALTH CONFERENCE TO BE HELD AT GRAND RAPIDS

The Michigan Public Health Conference, long held in Lansing, will be transferred to Grand Rapids for its eighteenth annual sessions Nov. 9, 10 and 11, it has been decided by the Board of Directors of the Michigan Public Health Association and the State Health Commissioner. Conference headquarters will be at the Pantlind Hotel and general sessions will be held in the Grand Rapids Civic Auditorium.

The conferences are sponsored jointly by the Michigan Department of Health and the Michigan Public Health Association. Organizations meeting in conjunction with the conference include the Michigan Association of Sanitarians, the State Organization for Public Health Nursing and the Michigan School Health Association. More than 1,200 health workers were registered at the 1937 conference.

\* \* \*

#### PUBLIC HEALTH GRANTS UNDER SOCIAL SECURITY ACT

Michigan's public health grant-in-aid for the fiscal year beginning July 1, 1938, under the terms of the Federal Social Security Act will total \$369,399.70, the Michigan Department of Health has been notified.

Of this total, \$260,399.00 has been allotted to Michigan by the U. S. Public Health Service under the terms of Title VI of the Social Security Act "for the purpose of assisting states, counties, health districts, and other political subdivisions of the states in establishing and maintaining adequate public health services, including the training of personnel for state and local health work." This is a decrease from the \$292,732.00 received during the past fiscal year.

From the Children's Bureau under the provisions of Title V of the Social Security Act, the Michigan Department of Health will receive during the next fiscal year a total of \$109,000.70 for the development and maintenance of services for promoting the health of mothers and children. A total of \$99,103.76 was received for this purpose during the 1937-38 fiscal year.

\* \* \*

#### SEROLOGIC TESTS ON MARRIAGE LICENSE APPLICATIONS

During the first six months of operation of Michigan's Antenuptial Physical Examination Law (Act 207, P.A. 1937), a total of 292 positive serologic tests

July, 1938



## REGULATION

Regulation of the daily program, especially diet and exercise, is beneficial to normal bowel movement and in some cases of constipation serves as sufficient treatment. Others require additional aid to facilitate regular evacuation . . . When an adjunct to diet and exercise is required, as it often is, Petrolagar provides a mild but effective treatment. Its miscible properties make it easier to take and more effective than plain mineral oil. Further, by softening the feces, Petrolagar induces large, well formed stools which are easy to evacuate. The five types of Petrolagar afford a choice of medication adaptable to the individual patient. Petrolagar Laboratories, Inc., 8134 McCormick Blvd., Chicago, Illinois.

*Petrolagar . . . Liquid petrolatum  
65 cc. emulsified with 0.4 Gm. agar  
in a menstruum to make 100 cc.*





for syphilis have been reported by the laboratories of the Michigan Department of Health and the qualified registered laboratories of the state. Twenty-six doubtful tests were also reported during this period.

The Department laboratories made a total of 12,177 serologic tests, of which 166 were positive and 24 doubtful. Approximately 1.4 per cent of all the tests showed positive indications of syphilis. The total number of tests made by the registered laboratories is not available.

A record of violations and complaints concerning this law is being maintained by the Michigan Department of Health for reference in formulating proposed changes in the present law. Reports from physicians and health officers of violations or pertinent observations on the administration of the Antenuptial Physical Examination Law will be welcomed by the Department.

\* \* \*

### SYPHILIS TREATMENT OUTLINES FOR PHYSICIANS

The Advisory Committee on Syphilis Control of the Michigan State Medical Society has prepared pamphlets on "Suggested Outlines for the Treatment of Syphilis" and "Syphilis Treatment Technic, Complications and Reactions."

These pamphlets have been published by the Michigan Department of Health and will be sent free to any physician upon request. The suggested outlines include recommended treatment schedules which are in accord with the considered opinion of leading syphilologists. The treatment schedules may be applied with drugs similar to those supplied by the Michigan Department of Health. General directions for preparation and injection of arsenicals are

presented in "Syphilis Treatment Technic, Complications and Reactions" as well as a description of possible immediate and delayed reactions or complications.

\* \* \*

### UNIFORM SANITARY REGULATIONS

The Michigan Department of Health is coöperating with the Bureau of Foods and Standards of the State Department of Agriculture and the State Liquor Control Commission in the formulation of uniform rules and regulations for the control of all establishments where food or drink is manufactured, handled, prepared, stored or served.

Special regulations will apply to establishments where only food is served and to establishments where beer, wine or liquor are served. The regulations will be posted in all food establishments. The printed regulations are expected to be available before the opening of the summer resort season. Sanitarians of local health departments may be deputized by the Bureau of Foods and Standards for the enforcement of these rules and regulations.

\* \* \*

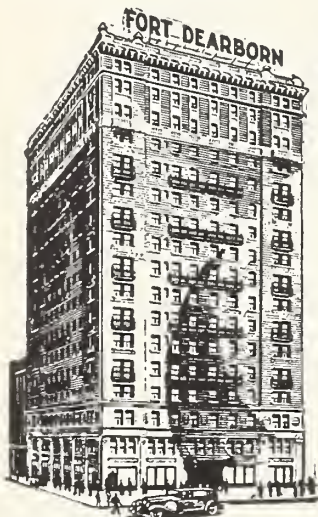
### FEDERAL SYPHILIS PROGRAM

The Michigan Department of Health will receive \$77,000 from the U. S. Public Health Service during the next fiscal year to finance syphilis control activities in this state as part of the \$3,000,000 national syphilis program proposed under the recently-enacted LaFollette-Bulwinkle bill, the State Health Commissioner has been notified.

These funds will make possible more extensive and conveniently located laboratory facilities for the diagnosis of syphilis, state-wide free distribution of antisyphilitic drugs to physicians, lay and profession-

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Every room bright and new in furnishings and decorations. All public space thoroughly modernized. Better service—finer food—with rate economy still the feature.

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## DISEASES OF THE RECTUM

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Sanitarium Hotel Accommodations

al educational activities, follow-up of infectious cases and sources of infection, and treatment of indigent cases.

\* \* \*

### PERSONNEL CHANGES

Dr. M. B. Beckett has resigned as director of the Allegan County Health Department to become district director of the W. K. Kellogg Foundation program in Allegan and Van Buren counties. Dr. James A. Dolce will succeed Dr. Beckett as director of the Allegan County Health Department. Dr. T. E. Gibson, former health officer of Eaton County, is now director of the Van Buren County Health Department, succeeding Dr. Frank Carroll.

Dr. C. D. Barrett, former director of the Bureau of Communicable Diseases, Michigan Department of Health, is directing the recently-organized Ingham County Health Department and the Michigan Training Center at Mason. Dr. Richard Sears is directing the activities of the Muskegon County Health Department during the absence of Dr. R. J. Harrington.

Dr. R. T. Westman, director of the Bay County

Health Department, with headquarters at Bay City, has resigned, effective July 1. Dr. F. J. Austin has also resigned as director of the Houghton-Keweenaw Health Department as of July 1.

\* \* \*

### AUTOMOBILE FATALITIES DECREASING

Deaths due to automobile accidents in Michigan appear finally to have reached the peak of their steady increase during the past decade. During the early months of 1938 there has been a 41 per cent decline in mortality on Michigan's highways.

A total of 354 deaths were recorded during the first four months of the year, compared with 601 during the same period in 1937. There were 115 automobile deaths in January this year, 72 in February, 81 in March and 86 in April. Michigan's vigorous education, licensing and law enforcement campaign during the past six months has brought results in that this state is ranked among the leaders in the national campaign to reduce mortality from this cause.

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## ◆ General News and Announcements ◆

### THE ONE HUNDRED PER CENT CLUB OF THE MICHIGAN STATE MEDICAL SOCIETY

1. Barry County Medical Society
2. Cass County Medical Society
3. Chippewa-Mackinac County Medical Society
4. Clinton County Medical Society
5. Delta County Medical Society
6. Dickinson-Iron County Medical Society
7. Eaton County Medical Society
8. Gogebic County Medical Society
9. Hillsdale County Medical Society
10. Houghton-Baraga-Keweenaw County Medical Society
11. Ingham County Medical Society
12. Jackson County Medical Society
13. Lapeer County Medical Society
14. Lenawee County Medical Society
15. Livingston County Medical Society
16. Luce County Medical Society
17. Manistee County Medical Society
18. Mecosta-Osceola County Medical Society
19. Menominee County Medical Society
20. Midland County Medical Society
21. Muskegon County Medical Society
22. Newago County Medical Society
23. O.M.C.O.R.O. County Medical Society
24. Oceana County Medical Society
25. Ontonagon County Medical Society
26. Ottawa County Medical Society
27. Saginaw County Medical Society
28. St. Clair County Medical Society
29. Schoolcraft County Medical Society
30. Shiawassee County Medical Society
31. Tuscola County Medical Society
32. Wexford-Kalkaska-Missaukee County Medical Society

The list of county medical societies which have recorded 100 per cent paid membership for the year 1938 is growing. Is your society listed above? Several societies have reported dues for all their members except one or two. If your dues are still unpaid, please contact your county secretary today; you may be able to put your society in the 100 per cent classification.

*"Make new friends, retain the old,  
The former are silver, the latter are gold."*  
L. J. G., Detroit.

*President Henry Cook* addressed the School Health Education Institute in Ann Arbor on May 27. His subject was "The Place of the physician on the school health program."

*Word has just been received* of the death, on June 1, 1938, of Macomb G. Foster of the firm Fairchild Bros. and Foster of New York City. Our sincere sympathy is extended to the family.

*If you know of a community where a young physician might locate*, please contact the Placement Bureau, 2020 Olds Tower, Lansing. A number of physicians who have just finished their internship are looking for available openings.

*"What Everyone Should Know About Cancer"*—a booklet prepared in 1938 by the Michigan State Medical Society Cancer Committee—was mailed to each member of the State Society in June. Additional copies may be secured by writing the Executive Office, 2020 Olds Tower, Lansing.

*At the funeral services* for Mervin Tomlin of Port Huron, member of the Michigan Legislature, Councilor T. F. Heavenrich, M.D., and J. H. Burley, M.D., of Port Huron, represented the Michigan State Medical Society and the St. Clair County Medical Society.

*"Does your firm advertise in THE JOURNAL of the Michigan State Medical Society?"* or "Do you have an exhibit at the Detroit Convention next September?" should be questions asked by you of every detail man who seeks your patronage.

Patronize those who support you.

\* \* \*

*Safe! All products advertised on the pages of THE JOURNAL of the Michigan State Medical Society have been tested and approved.* They are safe for you to use and prescribe. Don't take a chance and prescribe untested, and perhaps dangerous drugs. Patronize firms who advertise their tested and approved products in THE JOURNAL.

\* \* \*

*Dr. Christopher J. Stringer* began his duties in May as superintendent and medical director of the Ingham County Tuberculosis Sanatorium, replacing Dr. George C. Stucky, who had held the position since 1925. Dr. Stringer was graduated from the University of Iowa in 1931, and has been at the Herman Kiefer Hospital in Detroit for several years.

\* \* \*

*The Missouri Medical Association's House of Delegates*, at its 1938 annual meeting, passed the following resolution: "The Basic Science Law is fair and impartial. It is progressive legislation, designed to meet modern needs. Your committee recommends that the Committee on Public Policy be directed to introduce a Basic Science Act in the 1939 session of the state legislature."

\* \* \*

*An amendment to the Social Security Act*, namely, Bill No. S3541, embodying a rehabilitation program for tuberculosis, has been introduced into the Senate, and, if passed, will take effect on July 1. Three million dollars for the first year, four million the second, and five million thereafter for each year, will be set aside to provide for the cost of living expenses and a period of training.

\* \* \*

*Dr. William Donald* of Detroit has taken a very keen and intelligent interest in the medical department of the Detroit Public Library. His latest venture is a non-medical corner of the medical library which consists of books by doctors written by doctors on non-medical subjects, a sort of leisure hour department. Dr. Donald reports recent contributions to the number of twenty-three.

\* \* \*

*Let's go out to the ball game!* The Detroit Tigers will be at home in Detroit prior to, during, and immediately after the 1938 Detroit Convention of the Michigan State Medical Society next September:

September 15, 16, 17—playing New York  
September 18, 19—playing Washington  
September 20, 21—playing Philadelphia  
September 22, 23, 24, 25—playing Cleveland.

\* \* \*

*The Public Health Committee* of the Detroit Chamber of Commerce has invited Dr. Bruce H. Douglas, president of the Michigan Tuberculosis Association, to make a survey in Hawaii of conditions for the control of tuberculosis. The Detroit Public Health Committee is working in coöperation with the Territorial Health Department, the Council of Social Agencies, the Territorial Medical Society and other interested groups. Dr. Douglas sailed for Hawaii in June and expects to return in August.

*Hotel reservations should be obtained early if you are planning to attend the 1938 Detroit convention next September. A record-breaking attendance is being planned for and choice hotel accommodations will be taken fast. Plan now to be a part of the greatest convention in the history of the Michigan State Medical Society. Remember the dates: September 20, 21, 22, 1938; the place: The Book-Cadillac Hotel, Detroit.*

\* \* \*

*Recovery—or Deeper Depression?—The answer is up to YOU. Next November 8, 435 United States representatives and some 32 U. S. Senators, as well as 132 Michigan legislators, will be elected—by you. All who are engaged in business enterprises, small as well as large, must be actively concerned in the election this year.*

*It's up to you to sweep in Recovery on election day—with your vote.*

\* \* \*

*A physician is wise to carry personal liability insurance on automobiles for larger sums than the average member of society. The reasons are that the danger of a very large judgment is a real one, and the cost of the extra coverage is relatively small. One can double the coverage for as little as fifteen per cent additional. This protection is important if one were so unfortunate as, in a recent case, to run into a busload of people and injure a number of them.*

\* \* \*

*Please certify to the Executive Office, 2020 Olds Tower, Lansing, at least thirty days in advance of the annual meeting (no later than August 19), the names of any of your members for whom Honorary, Retired, Emeritus or Associate Membership in the State Society will be sought next September. The membership records of physicians, recommended by county medical societies for special memberships, must be checked before final submission to the House of Delegates.*

\* \* \*

*Crippled and Afflicted Child Commitments for May, 1938, were as follows: Crippled Children: total cases, 376, of which 112 went to University Hospital and 254 went to miscellaneous hospitals. Of the above, Wayne County sent 82 to hospitals of which 9 went to University Hospital and 73 went to miscellaneous hospitals.*

*Afflicted Children: Total cases 1,998 of which 266 went to University Hospital and 1,732 went to miscellaneous hospitals. Of the above, Wayne County sent 553 to hospitals, of which 32 went to University Hospital and 521 went to miscellaneous hospitals.*

\* \* \*

*A "Preventive Medicine Reunion" will be held at the Book-Cadillac Hotel, Detroit, September 21, 1938, with a luncheon. All those members of the Preventive Medicine Committee during former years are especially invited and urged to attend this luncheon. All others who are interested in preventive medicine are cordially invited to attend.*

*The speaker will be John Gordon, M.D., of Boston, who has recently spent considerable time in Roumania. His subject will be "Highlights of Rural Roumanian Medicine." Plan now to attend this outstanding attraction.*


\* \* \*

*Dr. Gaylord S. Bates of Detroit has succeeded Dr. David Sugar as editor of the *Detroit Medical News*. Dr. Sugar has been editor of the *Medical News* for four years, during which time he has very ably revived the idea of journalism with a personality. Dr. Sugar's editorial page has been clear, virile, and entertaining. He has proved himself a master in the writing of quotable paragraphs. He*

JULY, 1938

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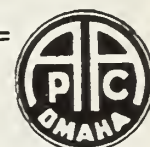
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### Serums

Antitoxins  
Bacterins

### Vaccines

Media  
Pollens

We are completely equipped and solicit your inquiry for these lines as well as for Pharmaceuticals, Chemicals and Supplies, Surgical Instruments and Dressings.

The Rupp and Bowman Co.  
319 Superior St. Toledo, Ohio

has served the Wayne County Medical Society well and has the sincere gratitude of all its members. The arduous duties of editor so ably performed by Dr. Sugar will now, as mentioned, be the work of Dr. Gaylord S. Bates, who, while new, possesses the personal qualities and mental equipment that will enable him to carry on the torch so brilliantly lighted by his predecessors. Dr. Bates received his academic education at Hiram College in Ohio. From there he attended Harvard University Medical School, where he was graduated in 1928. Following his graduation, he spent four years' surgical internship at Harper Hospital, Detroit. Following his internship at Harper, Dr. Bates was associated with Dr. Hugo Freund of Detroit. His practice is confined to surgery and he is now located in the David Whitney Building. He is a Fellow of the American College of Surgeons. THE JOURNAL wishes Dr. Bates every success in his new venture.

\* \* \*

The working man, who must be very conscientious and careful about his budget these days, feels that medical service deserves to be placed in the family budget ahead of luxuries. He is aghast at the figures of the annual expenditure per average family for luxuries.

Passenger automobiles .....	\$150.00
Tobacco .....	67.00
Gasoline (non-commercial) .....	37.00
Candy .....	37.00
Movies and entertainment .....	35.00
Soda waters, ice cream and gum.....	34.00
Jewelry and furs .....	29.00
Liquor (Michigan, 1935) .....	22.00
Radios and musical instruments.....	16.00
Cosmetics .....	15.00

\$442.00

\* \* \*

Are your indigent patients being granted necessary medical care? If not, start educating your local welfare authorities who are charged with the legal and financial responsibility of supplying this necessity to wards of the county. If medical care of indigents is not allowed, or if it is the first item eliminated when a welfare budget is curtailed, the blame is placed—not on the constituted authorities who control the situation—but on the physicians. The resulting cry is for State Medicine with salaried doctors!

Start educating your welfare authorities that medical care is a necessary commodity, like food, clothing, or shelter, or fuel; that often, proper medical care at the right time—rehabilitation—permits a man to obtain employment and get off the dole. This is *your* responsibility: Education.

\* \* \*

"The Doctor" now in a permanent home. The \$150,000 reproduction of the Sir Luke Fildes masterpiece "The Doctor" first shown by the Petrolagar Laboratories at Chicago's Century of Progress Exposition in 1933, was recently presented by its owners to the new Rosenwald Museum, of Science and Industry in that city.

Following the two World's Fairs, "The Doctor" exhibit went on a tour of 50,000 miles and was viewed by over five million people in eighteen principal cities throughout the country. Designed to remind the public of the importance of the family physician, it required the full time of the late Chicago sculptor, John Paudling and the noted artist Rudolph Ingerle and a large corps of assistants, and took nearly a year to complete. In its new location in the Rosenwald Museum it will be seen by millions of visitors annually.

\* \* \*

Blind and Deaf Children.—The educational program in the state for both the blind and the deaf groups is greatly handicapped by lack of an early

## Cook County Graduate School of Medicine

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Incorporated not for profit

### ANNOUNCES CONTINUOUS COURSES

MEDICINE—Special Courses During August Including Electrocardiography and Heart Disease, Gastro-Enterology in August and October.

SURGERY—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technique with practice on living tissue; Clinical Course; Special Course. Courses start every Monday.

GYNECOLOGY—One Month Personal Course starting August 22nd. Gynecological Pathology by Dr. Schiller starting July 25th. Two Weeks Course starting October 10th.

OBSTETRICS—Two Weeks Intensive Course starting October 24th. Informal Course starting every week.

FRACTURES AND TRAUMATIC SURGERY—Informal Course; Intensive Formal Course starting October 10th.

DERMATOLOGY AND SYPHILOLOGY—Two Weeks Special Course starting September 19th. Clinical Courses starting every week.

CYSTOSCOPY—Ten-day Practical Course rotary every two weeks.

General, Intensive and Special Courses in all branches of Medicine, Surgery and the Specialties every week.

TEACHING FACULTY—Attending Staff  
of Cook County Hospital

### ADDRESS:

Registrar, 427 South Honore Street, Chicago, Ill.



census of these children. In order to be of service to the parents of the blind child in preventing "blindisms" and queer personality developments, the State Department of Public Instruction wishes to be informed of each child at the earliest possible moment. In the case of the deaf, diagnosis is of course more difficult, but special training should be started in the home as early as three years of age. Otherwise these children grow up to school age without having developed any conception of language. A system of reporting the blind and the deaf children on identification is a highly desirable service. Please supply the names of such cases to your local school authorities, or to the State Department of Public Instruction, Lansing.

\* \* \*

B. R. Corbus, M.D. of Grand Rapids was re-elected as chairman of the Joint Committee on Health Education at its meeting at the Michigan Union, Ann Arbor, on June 2. The Joint Committee is composed of representatives of the following organizations:

Michigan State Medical Society  
Michigan Department of Health  
Michigan Public Health Association  
Michigan Hospital Association  
Michigan Tuberculosis Association  
Michigan State Nurses Association  
Michigan State College  
University of Michigan  
Michigan Division, American Red Cross  
Wayne County Medical Society  
State Conference of Social Work  
Probate Judges Association of Michigan  
Woman's Organization for Non-Partisan Reform  
Michigan Education Association  
Michigan State Dental Society  
Michigan Association of School Physicians  
Michigan Association of Sanitarians  
Michigan Congress of Parents and Teachers  
Michigan State Federation of Women's Clubs  
Michigan Home Economics Association  
Michigan Physical Education Association  
Wayne University College of Medicine and Surgery  
State Department of Public Instruction  
Children's Fund of Michigan  
W. K. Kellogg Foundation  
Horace H. and Mary A. Rackham Fund  
McGregor Fund

*Costs of public relief* in April continued the rise recorded for the six preceding months, according to figures issued today by the Social Security Board. Total federal, state and local costs incurred for aid to the needy in April, including earnings under the Works Program, amounted to \$242,931,000, an increase of \$7,772,000, or a little more than 3 per cent, over the total for March.

Figures reported by the Board are compiled regularly in collaboration with other Federal agencies and state and local authorities. The April figure includes amounts for the various programs as follows: Public assistance to the needy aged, to the needy blind, and to dependent children from federal, state, and local funds under the Social Security Act, and other public assistance of these special types, \$41,522,000; earnings under the Works Program, including the Works Progress Administration and other federal agencies through which wages were paid to persons certified as in need of relief, \$139,209,000; Civilian Conservation Corps, \$18,311,000; subsistence grants under the Farm Security Administration, \$2,336,000; general relief in cash and in kind, by states and localities, \$41,553,000. These sums represent substantially all public aid received by the needy, with the exception of aid to transients. Administrative costs are not included.

On the basis of reports received by the Board it was estimated, after allowance for duplications, that in April approximately 6.4 million different households, probably comprising about 20 million persons, received public aid of one or more of the types mentioned above. As compared with March, there was an increase of less than 2 per cent in the number of different households in receipt of public aid.

According to reports from states cooperating in public assistance programs under the Social Security Act, costs of \$40,636,658 were incurred in April for payments from federal, state, and local funds to recipients of old-age assistance, aid to the blind, and aid to dependent children. In April there were 1,671,223 recipients of old-age assistance in forty-seven states, the District of Columbia, Alaska,

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1 Tablet  $\approx$  1 cc. Solution  $\approx$  1½ grains Powder.

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(In affiliation with COOK COUNTY HOSPITAL)

Incorporated not for profit

Announces Post-Graduate Course in  
DERMATOLOGY AND SYPHILOLOGY

The members of the Division of Dermatology offer a two weeks intensive course starting September 19. The course will include the treatment of syphilis in all its phases. Cases will be demonstrated and the treatment outlined. The following lectures will be included:

Anatomy of Skin; Functions; Pathogenesis of Lesions;  
Care of Normal Skin.  
Eczema and Dermatitis Venenata.  
Fungus and Yeast Infections.  
Syphilis of Skin—Principles of Antisyphilitic Treatment  
Reactions to Drugs.  
Tuberculosis Cutis and Allied Diseases.  
Scaly Papular Eruptions.  
Diseases Due to Viruses and Animal Parasites.  
Acne and the Pyodermas.  
Tumors—Epithelioma, Precanceroses and Nevi.  
The Bullous Eruptions.  
Cutaneous Manifestations of Systemic Diseases; Lympho-  
blastomata, Lipoidoses, etc.  
Physical Agents in Treatment of Skin-diseases; Princi-  
ples of Treatment.

For circular write:

Registrar, 427 S. Honore Street Chicago, Illinois

and Hawaii, comprising approximately 21 per cent of the estimated population aged 65 and over. The average payment per recipient was \$19.29 for that month, ranging from \$4.65 in Mississippi to \$32.53 in California. In 36 states, Hawaii, and the District of Columbia, making payments under the program for April, aid was extended to 37,263 blind persons. The average payment for the month was \$23.53. In 38 states, the District of Columbia, and Hawaii, aid was provided for April on behalf of 586,293 dependent children in 236,791 families. The average monthly payment was \$31.76 per family.

\* \* \*

## UPPER PENINSULA MEDICAL SOCIETY

Sault Ste. Marie, Michigan

### PROGRAM

Thursday, August 18, 1938

#### *Morning*

Welcome Address—Honorable Paul Adams, Mayor,  
Sault Ste. Marie

Addresses—W. T. King, M.D., President, Upper  
Peninsula Medical Society

Don W. Gudakunst, M.D., State Health  
Commissioner

L. O. Geib, M.D., Chairman, Preventive  
Medicine Committee, Michigan State  
Medical Society.

L. Fernald Foster, M.D., Secretary,  
M.S.M.S.

Wm. J. Burns, LL.B., Executive Secretary,  
M.S.M.S.

#### Luncheon

#### *Afternoon*

"Peripheral Vascular Diseases—with Special Ref-  
erence to Varicose Ulcers and Varicose  
Veins"—Walter G. Maddock, M.D., Ann  
Arbor

"Back Pain"—Carl E. Badgley, M.D., Ann Arbor

"Nephritis and Pyelonephritis"—Floyd H. Lashmet,  
M.D., Petoskey

#### *Evening*

Banquet—6:30 p. m., Objibwa Hotel.

"A Doctor's Inventory"—James D. Bruce, M.D., Ann  
Arbor, Director of Postgraduate Medical  
Education, University of Michigan.

Friday, August 19, 1938

#### *Morning*

"Fracture of the Long Bones"—Carl E. Badgley,  
M.D., Ann Arbor

"The Relationship of County Health Units to the  
Profession"—W. W. Bauer, M.D., Director  
of Bureau of Health and Public Instruc-  
tion, American Medical Association, Chicago

"Management of Gall Bladder Disease"—Walter G.  
Maddock, M.D., Ann Arbor

## IN MEMORIAM

### Dr. David R. Clark

Dr. David R. Clark, a physician and psychiatrist in Detroit for thirty years, died July 3, 1938, following an operation for abdominal tumor. Dr. Clark was born in Port Clinton, Ohio, on January 26, 1874. He attended school in Port Clinton and Ann Arbor, and was graduated from the University of Michigan Medical School in 1895. After graduation he began general practice in Niles, Michigan, and after three years he came to Detroit. Dr. Clark was head of the psychopathic department of Receiving Hospital and senior medical officer at St. Joseph's Retreat. Dr. Clark was vitally interested in the care of mental patients and alcoholics and advocated many reforms. Dr. Clark was a past president of the Detroit Society of Psychiatry and past president of the Receiving Hospital staff. He was a member of the Wayne County and the Michigan State Medical Societies, the American Medical Association, the American Psychiatric Association and the American College of Physicians. He also belonged to the Dearborn Country Club and the Au Sable Club. Dr. Clark leaves his wife, Mrs. Glen M. Clark; a son, David R.; a daughter, Mary Jane; and a brother, Dr. George R. Clark, a Detroit dentist.

### Dr. R. E. Cumming

Dr. Robert Effinger Cumming of Detroit died Thursday, June 23, 1938. Dr. Cumming was one of Detroit's outstanding surgeons for seventeen years. He was born in Staunton, Virginia, on August 7, 1894, and attended the Hampdon-Sydney College of Virginia, Kentucky Wesleyan College, University of Louisville, Columbia University and the Army Medical School. In 1917, he began to specialize in surgery in the United States Army, and from 1919 to 1921 served as chief of the genito-urinary surgery department of the Walter Reed Hospital in Washington. Following this, he came to Detroit, where he later became a member of the surgical staff of Receiving Hospital, Grace Hospital, St. Joseph's Mercy Hospital and the Charles Godwin Jennings Hospital. Dr. Cumming was a fellow of the American College of Surgeons, a member of the American Urological Association, the Wayne County Medical Society, the Michigan State and American Medical Associations. In 1934, he was president of the North Central Branch of the urological association, and also served as president of the Detroit branch. Dr. Cumming was active in church work in Detroit, where he was an elder in the First Presbyterian Church. He also held membership in various local clubs, including the St. Andrew's Society, the Detroit Country Club, the Detroit Club, Detroit Boat Club, Indian Village Club and the Fine Arts Society. Dr. Cummings leaves his wife, the former Pauline D. Anderson of Richmond, Virginia, and one daughter, Carolyn, seventeen years old. He is also survived by five brothers, William K., of Benton, Md.; Daniel J., of Mokpo, Korea; Bruce A., of Kwangju, Korea; and Colin and Dr. Richard C., of Ocala, Fla.; and a sister, Miss Lucy Cumming, of Ocala, Florida.

### Dr. Charles J. Ennis

Sault Ste Marie has lost her oldest physician in the death of Dr. C. J. Ennis who died on June 11 at  
JULY, 1938

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the advanced age of eighty-seven years. Dr. Ennis had lived at the Sault for fifty-four years. He was born August 30, 1850, at Dublin, Ireland. He attended Belvidere College and the Carmichael School of Medicine, and graduated from the College of Surgeons at Dublin in 1874. Following his graduation, he visited a number of British colonies as physician including the great convict settlement in Perth, Australia. On his way to the Far East, he arrived at the Sault where he made up his mind to go no farther. He resigned the colonial service and settled down to practice in the American town. About this time, he married Miss Lydia Cunning-

ham, whom he met in Buffalo. She died in 1927. There were no children.

Dr. Ennis organized the first medical society in Sault St. Marie and served a number of terms as head of the society. He was also active in civic affairs. Dr. Ennis' Irish wit and talent made him very popular as an after-dinner speaker, and many times he filled the rôle of toastmaster.

The *Evening News* of Sault St. Marie commented on his democratic spirit and service to his community as follows: "In the recording angel's great book the name of Dr. Charles J. Ennis, no doubt, stands high among the names of those who loved their fellow men. God may have a special niche reserved for country doctors, but if we are right in estimating Dr. Ennis' love for companionship, friendship and unselfish service, his spirit will soon be hob-nobbing with the spirits of Tom, Dick and Harry in heaven as he did on earth. . . . He was an institution in Sault Ste. Marie. He belonged to another age, but life never passed him by. That bright twinkle in his eye never dimmed, that Irish wit always thrilled to life and the joy of living, and that disregard for self always kept him up front." Dr. Ennis was a member of the Chippewa County, Michigan State and American Medical Associations.

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### Dr. Robert Carl Humphrey

Dr. Robert Carl Humphrey of Detroit died recently. He was born December 23, 1907, in Detroit, and received his education in local institutions. He was graduated from the Wayne University Medical School and interned at Receiving Hospital. Later he became a resident physician at the Wyandotte General Hospital and followed this by entering general practice. At the beginning of this year he became a staff physician at the Lapeer Home and Training School. Dr. Humphrey was a member of the Wayne County and Michigan State Medical Societies, the American Medical Association and Nu Sigma Nu fraternity. He is survived by his wife, Mrs. Alma Humphrey, his parents and two sisters.

### The Memory of Dr. Manwaring Honored

On February 13, 1938, the members of the Genesee County Medical Society, including the staff of the Hurley Hospital, assembled to witness the presentation of the plaque by the board of management of Hurley Hospital in appreciation of the gift of the library of the late Dr. J. G. R. Manwaring to the hospital. The wording of the plaque is:

In Memory of  
J. G. R. Manwaring  
Physician, Surgeon  
Teacher—1877-1935

Addresses were made by Dr. W. A. Marshall who took as his subject, "Dr. Manwaring, the Physician," and Dr. H. E. Randall, who spoke on "Dr. Manwaring, the Surgeon." Dr. A. McArthur, president of the Genesee County Medical Society, presided and Dr. F. E. Reeder accepted the plaque on behalf of the hospital. The addresses of Dr. Marshall, Dr. Randall and Dr. Reeder, which are too long to reproduce here, are splendid expressions of tribute to the memory of one of their colleagues who had accomplished so much in a life that was cut short in its prime.

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## CONGENITAL ANOMALIES WITH PARTICULAR REFERENCE TO CRYPTORCHIDISM, HYPOSPADIAS AND CONGENITAL ABSENCE OF THE VAGINA\*

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Congenital anomalies of the genito-urinary tract in both the male and female occur sufficiently often to justify frequent consideration. These conditions usually are seen among robust persons who otherwise are healthy; therefore, correction of the defect is requested both from a physical and psychologic point of view. It is a matter of record that many patients commit suicide when they discover the defect and are informed of the attendant possibilities regarding their reproductive function and some of the difficulties and failures of surgical correction. A senior medical student in one of the English hospitals and medical school, who had bilateral cryptorchidism, went to his room and took his own life when he was told that persons who had bilateral cryptorchidism were sterile, yet the postmortem report revealed normal spermatozoa in his seminal vesicles.

The defects with which I am most frequently concerned are cryptorchidism, hypospadias and congenital absence of the vagina. Cryptorchidism and hypospadias are not infrequently associated. Some of the same principles in the more recent methods of correction of hypospadias have been applied successfully to reconstructing an artificial vagina in congenital absence of the vagina or stricture of a previously normal vagina. Furthermore, these three conditions are surgical problems encountered among youthful patients or young adults and must be corrected early in life so that the organs affected will have a chance for normal development and function.

### Cryptorchidism

It seems to me that the questions involved in the treatment of cryptorchidism have been rather satisfactorily settled although there no doubt will be new suggestions and modifications of previously described operations for its surgical care. The result required by any treatment is that the testis remains in the dependent portion of a well developed scrotum, so that the function and development of the testis is not disturbed.

There are a few basic facts that require mention before any methods of surgical procedure are discussed. For example, the spontaneous late descent of the testis has received more recognition since the published observations of Drake, who noted that this occurred when boys were fourteen years of age. It is this question of spontaneous descent, which is known to occur at various ages up to the age of puberty, that makes it so difficult to evaluate the results of the administration of anterior pituitary-like hormone. Should the descent occur

\*Read before the meeting of the Detroit Branch of the American Urological Association, Lansing, Michigan, April 9, 1938.



simultaneously with the administration of this hormone, one could assign the result to either the hormone or natural causes without justification. It seems fair and unbiased to assume that any undescended testis that is freely movable in the inguinal canal and that descends during hormone treatment would have most likely descended without the treatment. Hormone therapy apparently does influence the vascular supply of the testis and scrotum, and for this reason it may affect growth and development and thus influence descent of the testis. However, I do not know just now how undisputed facts regarding its influence on descent of the testis can be evaluated. In view of the frequent spontaneous descent, too much emphasis cannot be placed on the effect of hormone therapy.

Hormone therapy has a very definite place in the treatment of the cryptorchid who is less than twelve years of age, or, more accurately, who is a few years less than the age of puberty, when spermatogenic influence is initiated. Most students of this phase of treatment agree that if administration of 4,000 units of antuitrin S daily, five days a week, for four weeks, does not produce any appreciable change in the position of the testis, the treatment should be discontinued, as the likelihood of any subsequent beneficial effect from repetition or prolonged treatment is doubtful. However, should the testis descend during treatment, there is no indication for further treatment, but, if descent fails to occur, both the scrotum and testis are in a more favorable condition for surgical interference, since both structures become enlarged, softened and more pliable as a result of influence of the hormone. Since these changes have been observed it is logical to propose that all cryptorchids who have not reached the age of puberty and whose testes have never been seen in the scrotum should be given a preliminary course of hormone treatment since there is nothing to lose and it may be completely successful or may prove a distinct aid to subsequent surgical treatment.

Moore (and his collaborators) has done much to improve the results in the treatment of cryptorchidism by explaining scientifically the function of the scrotum and directing attention to its physical characteristics. They demonstrated for the first time the influence of temperature on spermatogenesis. It is now common knowledge

that, instead of the scrotum being just a receptacle or covering for the testes, it is a temperature-regulating mechanism, and in order to function as such the testis must be freely movable and in the dependent portion of the scrotum so that the scrotal wall can contract or relax around it as necessary, depending on the external temperature. The influence of a temperature greater than the scrotal temperature was shown by replacing the testes of several experimental animals in the inguinal canal or abdominal cavity for varying periods of time. When one testis was excised for study at the end of one week, the germinal epithelium was thoroughly disorganized. The longer the testis remained in this position, the greater were the destructive changes. When the other testis was replaced in the scrotum the germinal epithelium rapidly regained its normal characteristics. To demonstrate further the influence of higher temperatures on the testis, external heat was applied while the testis was in the scrotum and similar histologic changes were observed in the germinal epithelium. It was, therefore, firmly established by these observations that the undescended testes would most likely fail to develop and that spermatogenic function would probably be absent or at least seriously disturbed.

A further basic principle was established when Wangenstein demonstrated that if the testes of the dog were replaced in the abdomen before puberty the destruction of the germinal epithelium failed to occur, but it did occur if the testes of the adult dog were replaced in the abdomen. This confirmed the observations of Moore in this respect.

Moore and Wangenstein indisputably established some fundamental facts that are germane to the successful treatment of cryptorchidism; that is, that there is no danger involved by postponing surgical treatment until the child is ten or twelve years of age and there is no advantage in operating on the child when he is at the diaper age. Furthermore, if the testis is to develop and function the scrotum must be adequate and the testis must remain in the dependent portion of the scrotum and be freely movable so that the scrotum may contract about it in order to obtain the full effect of the air-conditioning mechanism.

Any surgical procedure advocated for cryptorchidism should be one which will



adequately meet all of these requirements. It has been my experience that the Torek operation is most worthy of consideration.

In this operation the technic involved in

somewhat coiled and adherent. Very noticeable length is added to the cord when these bands are divided. I mention these few points in the process of lengthening the cord

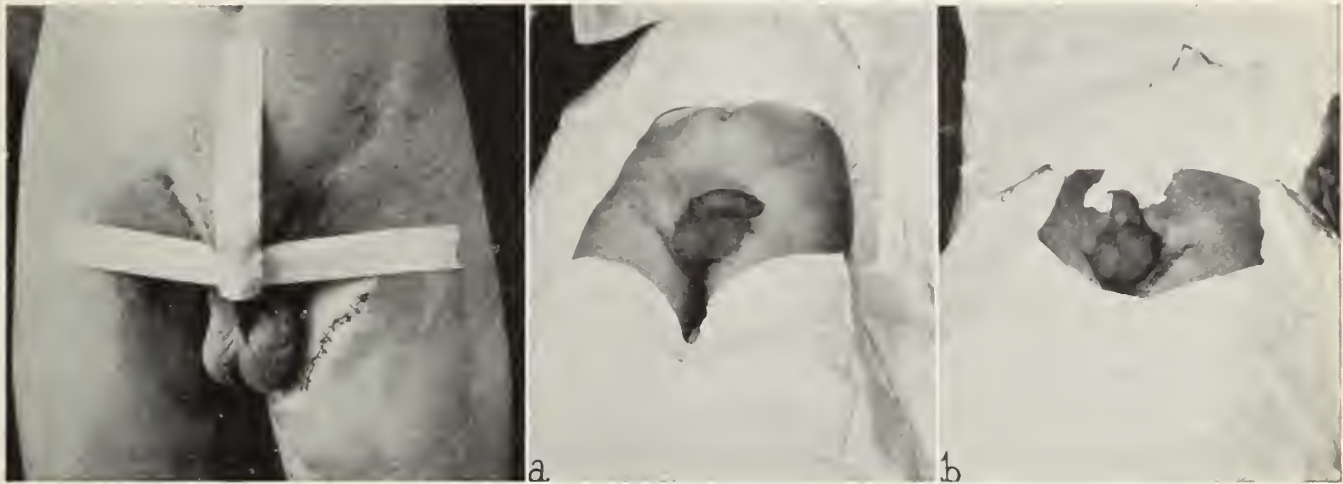


Fig. 1. Bilateral cryptorchid, both testes retracted to the inguinal canals two years after a Bevan operation was performed; two years later a bilateral Torek operation was performed, left testis and scrotum were removed from the thigh after one year.

Fig. 2. Bilateral cryptorchid. *a*, Torek operation completed on right side; left testis and scrotum attached to the thigh; *b*, completion of second stage of Torek operation on left side; one may note redundancy of scrotum and position of testes.

lengthening the spermatic cord is the same as that used in all other surgical procedures for cryptorchidism. It consists in separating the fibrous bands between the spermatic vessels, the hernial sac and the parietal peritoneum. These fibrous bands are most prominent near the neck of the peritoneal sac and extend upward from this point onto the posterior parietal peritoneum. In 15 per cent of cases there is no hernial sac and the adhesions are principally found along the peritoneum. The chief danger in this portion of the operation is injury to the spermatic artery and vein while they are being separated from the peritoneal sac. This portion of the operation is easily and safely executed if one elevates the spermatic cord and then determines the extent of the sac. It may remain open as a vaginal process in which the testis is situated. With the structures of the cord under slight tension the peritoneum adjacent to the vessels can be separated by fine blunt scissors and divided. As tension is maintained the fibrous attachment of the peritoneum to the vessels is plainly visible and can be sectioned without damage to the vessels. After separating these bands from the sac and parietal peritoneum, attention is next directed to those bands between the spermatic artery and veins; these bands usually are most numerous in that portion of the cord near the testis, where the vessels are likely to be

because at the attachment of these bands are the dangerous areas, and this part of the operation unfortunately happens to be the most important in subsequently placing the testis at the point where it can attain its full development and proper physiologic function. Injury to the vessels means atrophy of the organ, and failure to add sufficient length to the structures of the spermatic cord is certain to entail a poor result.

The main features that characterize the Torek operation and distinguish it from other methods are the attachment of the skin of the scrotum to that of the thigh and the attachment of the testis to the fascia lata. The advantages of this procedure seem to me to be absolutely clear. In the first place, the scrotum frequently is a rudimentary structure and this is especially true in bilateral cryptorchidism. It can, however, even in this condition, be manually stretched into a fairly sizable scrotum and then is maintained by attachment to the skin of the thigh. If this is not done, it is in a great many cases going to contract against the pubis, where the testis becomes adherent. All other procedures or modifications of this point in the technic seem to me to be inconvenient and troublesome, and, furthermore, the method of holding the testis and scrotum down is definitely limited in time. If the scrotum is manually stretched it must



be held in the new position for weeks or months before it can be released and expected to continue and develop as a normal structure. At The Mayo Clinic we have maintained attachment for over one year, as shown in Figure 1 and for nine months as shown in Figure 2, *a* and *b*. In both instances there was bilateral cryptorchidism and a rudimentary scrotum.

The testis is brought down within the tunica vaginalis and attached to the fascia lata. There is no interference with the blood supply and it can be separated whenever it seems that the scrotum has attained sufficient size and is prepared to assume its proper function of contraction and relaxation.

We have performed this operation on a good number of patients each year for the past ten years with excellent results.

### Hypospadias

The successful treatment of hypospadias is also predicated on two basic principles: namely, the correction of curvature and the construction of a urethra through which the patient can pass water and semen in a normal direction and manner. To accomplish this it has been observed through success and failure by many surgeons that these corrections should be performed at different periods in life if the treatment is instituted while the patient is less than ten years of age. If the patient is an adult, a long interval between correction of curvature and the construction of the urethra is obviously unnecessary.

Besides the correction of curvature and the construction of the urethra, another very important feature in the anatomy of the urethral meatus has been pointed out by Mr. A. Ralph Thompson, of Guy's Hospital, which seems to me to be necessary to take into consideration in reconstruction if the urinary passage is to be entirely normal. He states: "The normal meatus urinarius is rather a complicated structure. It is a vertical slit, and since the passage of the urethra is a horizontal slit a rifling action upon the flow of urine is produced, which aids in the act of micturition. This is well known, but it may not be so well known that two distinct vertical plaques lie one on each side of the normal meatus, somewhat like the appearance of stomata upon a leaf. They doubtless assist in closing the urethra after micturition, and thus prevent an undue for-

mation of drops at the meatus after the act. In any operation for the plastic cure of hypospadias, if this fovea glandis is present it should be preserved and used for the meatus, if this is possible." This feature reveals why many of the plastic operations for the construction of a urethra are faulty.

*Correction of Curvature.*—The basis of all successful surgical treatment in the correction of curvature is the complete removal of all scar tissue occupying the position of the missing part of the corpus spongiosum. There are two procedures generally used for this purpose by most surgeons, depending upon the extent of the deformity. The one consists of making transverse incisions in the penile and penoscrotal types. The usual procedure is an incision through the fibrous tissue on the ventral surface of the penis just below the glans and another just in front of the opening of the urethra. These incisions are then sutured vertically. It is highly important to section all of the fibrous tissue near the hypospadiac opening in order to permit the urethra to move backward to its normal position without tension. Thus, a penile hypospadias may become a penoscrotal type, and a penoscrotal hypospadias may become a perineal type.

In most instances, I believe, it is advisable to excise completely the fibrous tissue which occupies the position between the two incisions. It should be removed down to the corpora cavernosa, but the fibrous tissue in it should not be removed. The lateral skin flaps should be freely mobilized and brought together in the midline without tension.

A second method, which I believe has much to recommend it, is the principle of Edmunds, which disposes of the redundant dorsal prepuce by transferring it from the dorsal position to the defective ventral surface after the scar tissue has been completely removed. By this method the deformity can often be overcorrected, which often seems to me to be desirable. The utilization of the hooded prepuce assures a more normal appearance to the penis and greater mobility to the skin of the shaft.

Edmunds' method has been well described and illustrated. It consists in producing a buttonhole through the prepuce; the buttonhole should be large enough to admit the glans penis. This constitutes the first stage of the operation. In two to three weeks, when the blood supply is well established, the second stage of the operation is per-

formed. The buttonhole flap is divided and the edges of the skin are laid apart and transferred to the ventral aspect of the shaft, following the removal of the fibrous tissue at the site of the missing corpus spongiosum. This operation cannot be done if it is proposed to construct the urethra by means of the Ombrédanne operation. It, therefore, is imperative to decide at this point what method is to be used to construct a urethra.

It is now obvious that in treating hypospadias in children the correction of curvature must be done before the age of three years in order to secure the advantages that will accompany growth and development of the shaft of the penis.

*Construction of a Urethra.*—The optimal time for this stage of the proceeding is after the child has attained reasonable growth and yet some years before the advent of puberty. Most urologists are of the opinion that the construction of the urethra is best undertaken sometime in the sixth year after the deformity has been corrected, but some believe that it should be performed three or four years after the correction. It is important, whenever possible, that this part of the operative procedure be planned so that, in case even partial failure necessitates repeated operations, the whole procedure will be entirely complete by the age of nine years. In adults this procedure can be safely undertaken four to six months following correction of the deformity.

The diversion of the urinary stream, either by suprapubic cystostomy or perineal urethral drainage, is essential in most operations for hypospadias. When this is done constant attention is required to prevent occlusion of the tube drain and consequent soiling of the suture line of the new urethra, which, if permitted to ensue, would predispose to sloughing and to the formation of a fistula. The fear of the formation of a fistula and repeated failures at subsequent attempts to close them stimulated the development of operative procedures in which diversion of the urinary stream was unnecessary. Chief among these are the Ombrédanne operation and the McIndoe<sup>8</sup> modification of the Nove-Josserand method.

Most operations for hypospadias rely on some plastic method which utilizes local skin flaps; the chief methods have been the Thiersch operation and its modifications by Cecil, the Bucknall operation and its modi-

fication by Cabot, and the Ombrédanne operation. In Thiersch's operation the urethra is made by turning in flaps with broad bases that are cut parallel to the normal course of the urethra and so planned as to avoid the superimposition of the suture lines in the two layers. This operation has been highly successful, but it is prone to result in the formation of a fistula along the suture line, particularly near the penoscrotal angle, where tension is likely to be increased. One of its distinct advantages is that in no portion of the urethra is there any hair-bearing area.

The Bucknall operation utilizes scrotal flaps. In this method the inner layer of the urethra is formed from the tissue extending backward from the abnormally placed meatus, and since this lies behind the penoscrotal angle the urethra will involve the skin of hair-bearing area. Bucknall<sup>1</sup> called attention to this point in his original communication and warned that it might lead to serious complications. Cases in which a stone has formed around urethral hair have been reported by Vermooten and by Cabot. This complication induced Cabot to abandon the Bucknall operation. He recently devised a modification of this procedure. He constructed a urethra in a manner similar to the Bucknall operation but it was free of hair-bearing skin.

One of the distinct advantages of the Bucknall operation and its modifications is that the procedure is generally considered to be free from fistula formation because of the wide attachment of flaps adjacent to the canal that is lined with skin. Its greatest field of usefulness probably has been in adults and in cases in which previous methods have failed. In the adult the cosmetic result is usually bad but when the operation is performed in cases in which the patients are young children, the growth and development improve the result a great deal.

Another comparatively recent method which utilizes both scrotal and preputial skin flaps with a rather remarkable degree of success, especially in children, is the Ombrédanne operation. This method is applicable to the penile, penoscrotal and perineal types of hypospadias. The perineal and penoscrotal types are first converted into a penile type by elevating a longitudinal skin flap behind the urethral opening and reflecting it forward to construct a urethra which is then covered by lateral flaps of scrotal skin.



It is fundamental in using this method that all perineal and penoscrotal types of hypospadias be converted into the penile type as a preliminary procedure to the main part

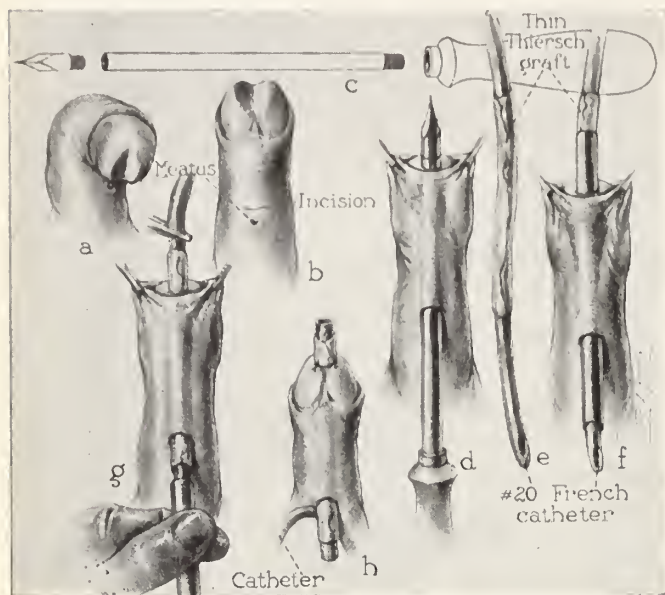


Fig. 3. *a*, Contracture of the penis; *b*, position of penis after excision of scar; *c*, trocar for carrying the urethral graft; *d*, trocar making site of new urethra; *e*, catheter covered with Thiersch skin graft corresponding to the length of the urethral defect; *f*, catheter and graft in position in the trocar; *g*, trocar being removed; *h*, graft-covered catheter in normal position and catheter inserted in bladder through the hypospadiac meatus.

of the operation, which consists of the construction of the penile portion of the urethra to the end of the penis by elevating a flap of skin posterior to the urethral meatus which is then covered by the skin of the redundant hooded prepuce. Many stages may be necessary to complete the entire urethra, especially in the perineal type of hypospadias.

Although this operation may be looked upon as simple to perform and free from any great risk of fistula formation, and although a urethra of good caliber and length is obtained, the procedure has some very definite disadvantages. First of these, it seems to me, is that in order to obtain a good cosmetic result as well as to correct the hypospadias the operation must be performed on children so that growth and development will obscure scar and deformity of the penis and scrotum. Repeated operations on children should be avoided wherever possible. In the perineal and penoscrotal type of hypospadias, the urethra is constructed of hair-bearing skin; the operation, therefore, is subject to the same criticism as is the Bucknall method, although difficulties from this source may be overestimated. Finally, multiple staged opera-

tions, which require a considerable stay in the hospital each time, are associated with much expense. Time and expense are nothing to the child, but if the patient is a young man they usually are a prominent economic factor.

To construct a urethra of good caliber and adequate length and to secure a good cosmetic result are plainly the most difficult parts of the surgical treatment. These problems are reflected in the many various applications of skin flaps and in the modifications which have been devised by competent urologists. Each modification is an attempt to avoid the formation of a fistula, the frightful deformity produced by scar tissue and the diversion of the urinary stream. In brief, surgeons have attempted to accomplish the desired result by the so-called fool-proof method. In this connection I might add that none of the older methods are astonishingly successful, and they do not reflect the results that we as urologic surgeons wish to display.

McIndoe<sup>8</sup> devised an operation that is based on an entirely different procedure. In this operation the Esser principle of inlay grafting is used to construct a urethra. No penile or scrotal skin is used; the danger of breaking of the sutures and the difficulties caused by urethral hairs are eliminated. I believe that this operation is capable of supplanting all previous methods. It consists of three simple fundamental steps, which are: (1) transferring the skin of the hooded prepuce to cover the denuded ventral surface of the shaft by the Edmunds method; (2) correction of the curvature, and (3) construction of a urethra with a thin Thiersch graft obtained from a portion of the inner surface of the arm that does not contain hair. The third step is performed two or three months after the correction of curvature. The Thiersch graft is placed around a urethral catheter of a size equivalent to a No. 18 French male catheter, and placed beneath the skin at the site of the missing corpora spongiosum by means of a sharp trocar which has been designed by McIndoe<sup>8</sup> (Fig. 3).

The trocar consists of a detachable cutting point and handle which are removed after the tunneling portion of the operation is completed. The tunneling is accomplished by making an incision in the skin just in front of the hypospadiac opening and by carefully pushing the trocar along beneath



the skin and bringing it out exactly at the meatal site in the glans penis. The cutting end of the trocar is removed and the catheter which is covered with the graft is grasped by a forceps and held in position while the shaft of the trocar is withdrawn in order to permit the skin to contract down on the graft.

The catheter is tied in this position, where it is allowed to remain for ten to fourteen days, when it can be withdrawn for irrigating purposes. At this time the epithelization of the canal is complete. The segment of catheter is maintained in position, however, for a period of three to six months, which is equivalent to the contractile phase of inlaying grafts. It was the disregard of this contractile period which, as McIndoe<sup>8</sup> has pointed out, resulted in failures or stenosis following the Nove-Josserand operation for hypospadias. McIndoe advised and applied the modern principle of inlay grafting, which maintains the canal in a distended position longer than the contractile phase for grafted skin. The average contractile period for a graft is six months. Stenosis does not occur if this principle is observed.

At the end of six months an end-to-end anastomosis is performed without difficulty over a catheter by suturing the posterior end of the new urethra to the hypospadiac meatus. Complete details of this technic are carefully explained in McIndoe's<sup>8</sup> original communication.

The chief advantages of this operation over operations that utilize the flap procedures are noteworthy. It produces an organ that is practically normal in appearance and it is associated with little scar formation. The urinary stream is ejected from the normal meatal site in the glans penis by utilization of the anatomic principles referred to by Mr. Thompson. This causes the stream to be projected in a nearly normal manner and prevents dribbling.

There is no need for diverting the urinary stream during the plastic construction of the urethra. This operation is applicable to all types of hypospadias and can be performed by most surgeons without fear of failure. The total period of hospitalization and expense are reduced considerably. In the cases in which I have performed this operation it has proved to be surprisingly satisfactory and easy to execute.

### Congenital Absence of the Vagina

The surgical treatment of congenital absence of the vagina is composed of many different procedures. Some of these utilize segments of the intestinal tract to form a vagina and others utilize skin flaps and pedicle grafts taken from the labia and from the skin of the thigh. Success and failure have attended all of these methods. Infection and sloughing of the transplanted segment of bowel were the usual causes of failure in cases in which this method has been used, and subsequent contraction and stenosis were the cause of failure in the cases in which skin flaps and pedicle grafts were used.

Not all patients who have congenital absence of the vagina should be treated surgically, but only those who are otherwise normally developed and who contemplate marriage. Some patients without a vagina also are without ovaries and the balance between prolactin and the estrogenic hormone therefore is abnormal and sexual indifference results. Patients who are normal in every other respect but who do not contemplate marriage need not be treated, since their health will not be affected by the defect. If patients have married before the existence of the defect became known, surgical reconstruction is, of course, essential. The psychologic basis for surgical interference in such cases is important. In many instances a sex neurosis develops when the patient learns of her condition, and she feels she will never be able to take her normal place in society. Occasionally, such a patient has resorted to suicide during a period of mental depression. A thoughtful discussion of the subject, in which it is clearly explained that the anomaly is not at all uncommon and can be corrected surgically, does much to appease the mental distress.

Graves was one of the earliest writers to report good results from pedicle grafts taken from the labia and also from the skin of the thigh by a method which he originated. He reported five cases in which this method was used in a period of thirteen years. Four of the patients had normal secondary sex characteristics. Since the labia in many cases are rather small, which makes it almost impossible to perform Graves' operation, modifications were advocated by Frank and Geist. They formed a tubular graft taken from the thigh and later placed it in the new site of the vagina. Grad later introduced mod-



ifications of the tubular graft, the purpose of which was to maintain greater blood supply and thereby guard against the development of necrosis.

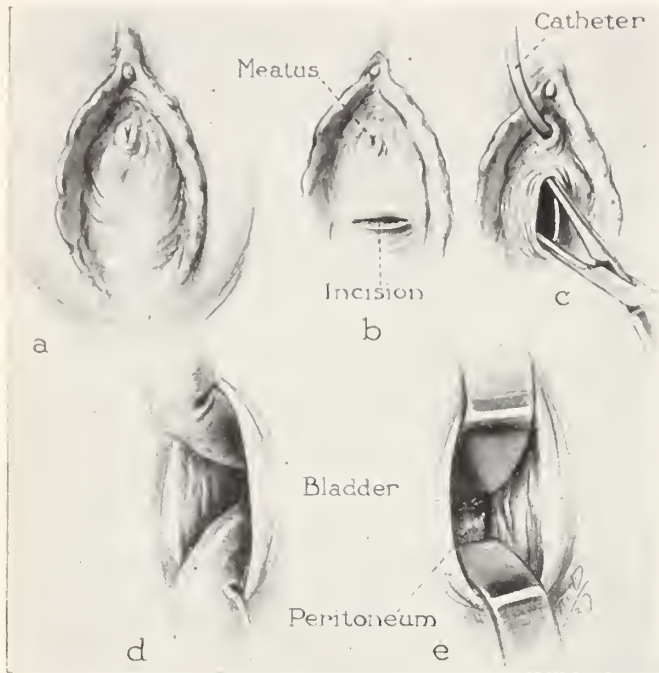


Fig. 4. a, Absence of evidence of vagina; b, transverse incision at new site of vagina and well away from the urethra; c, tissue separated by blunt forceps to locate the fascial plane between bladder and rectum; d, bladder and rectum being carefully separated with the fingers; e, peritoneum of the cul-de-sac being elevated by retraction to secure depth for a new vagina.

Although many good results have been reported following the use of skin and pedicle grafts, they have many disadvantages; the chief one is that subsequent secondary contraction will invariably ensue unless some method is employed to prevent it. This can be overcome, however, by constant dilatation during a period of four to six months; this can best be accomplished by a retained mechanical dilator. Another distinct disadvantage of skin and pedicle grafts is the prolonged period of hospitalization and the repeated operations necessary to correct the defect by multiple stage procedures. This entails considerable expense to the patient and furthermore makes it unwise for anyone to attempt the procedures if he is not familiar with plastic surgery and with the use of pedicle grafts.

Kirschner and Wagner, who were cognizant of the disadvantages associated with pedicle grafts as a routine method and who believed that the risk involved in using any part of the intestinal tract was perhaps too great to assume in correcting a defect which in itself was not a hazard to life, suggested a simple method of utilizing a large

Thiersch graft which was taken from the thigh and implanted into the vaginal position. In brief, this procedure necessitated opening the space between the bladder and

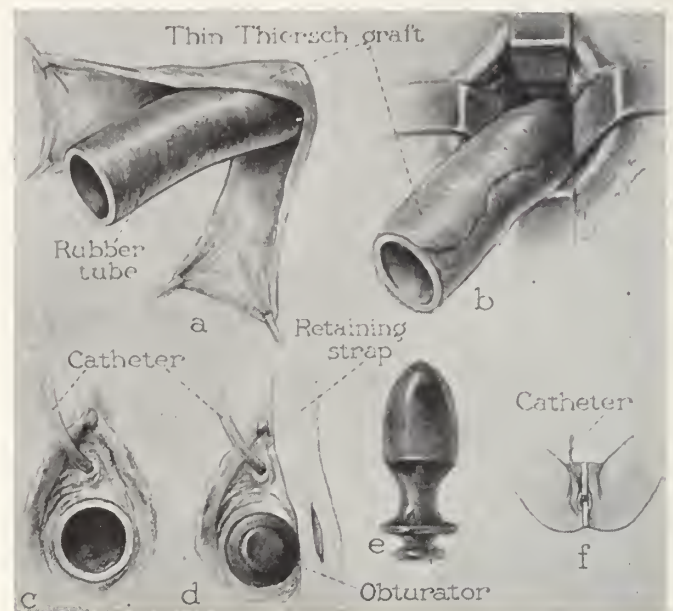


Fig. 5. a, Rubber tube which has been cut to correspond to the depth of the vagina is being covered with a complete Thiersch graft; b, graft being placed in position; c, graft and tube completely inserted; d, obturator placed in the end of the tube; e, obturator which is placed in tube to hold it in position; f, retaining strap fastened over the tube to maintain it in accurate position.

rectum up to the reflection of the peritoneum (Fig. 4). This latter structure was then pushed upward to add depth to the new tract. A solid rubber mold was constructed to conform to the depth and diameter of the new vagina, which usually measured 4 by 1½ inches (10 by 3.8 cm.). A Thiersch graft of sufficient size to cover the rubber mold completely was then cut in one piece from the skin of the thigh. This graft was then sewed onto the mold with catgut sutures. The mold carrying the graft was then carefully placed within the vaginal tract and held firmly in this position for two to three weeks. At the end of this period the mold could be removed and the vaginal canal was at this time completely covered with a thin layer of epithelium and closely resembled a normal vagina in every respect. Although Kirschner and Wagner and others in Germany who used the same method reported excellent results in most cases, there were a few cases in which contraction later produced some difficulty. They emphasized, however, that dilatation should be continued by the patient for a considerable time. The entire procedure was performed in one stage and the period of hospitalization rarely exceeded three weeks.

The surgical risk was reduced almost to a minimum.

In order to overcome the inconvenience which is caused by the necessity of wearing a vaginal dilator constantly, McIndoe recommended complete closure of the vulva over the mold and skin graft, but provided a small opening in the perineum for drainage. At the end of six months the contraction phase will have passed and the vulva can be opened and the mold removed without fear of secondary contraction. He said that keeping the mold in position in this manner did not inconvenience the patient.

I have further modified Kirschner and Wagner's method by utilizing a flexible rubber tube, over which the graft is placed, instead of a solid rubber mold (Fig. 5). The rubber tube can be cut to any desired length, which is necessary because of the fact that the distance between the perineum and the peritoneal reflection is variable in cases of congenital absence of the vagina. In my method the rubber tube is removed in ten to fourteen days and is replaced by a bakelite sound, which is made especially for each patient. A sanitary belt is worn by the patient; this belt fits firmly around the neck of the sound, which maintains it in a constant position. The sound is worn continuously for six months, but is removed once a day for cleansing purposes.

In the past fifteen months I have used this method in five cases of congenital absence of the vagina and in two cases in which stricture of the vagina followed delivery; in all the cases the results were satisfactory.

### Comment

There are certain basic principles underlying the surgical treatment of these congenital anomalies. In cryptorchidism it is essential that the testis be brought down before puberty and maintained in the dependent portion of the scrotum. In addition, it is important that, if the scrotum is rudimentary in type, the operation be so planned as to aid in the development of a scrotum. The Torek operation fulfills all

these basic requirements and an extremely high incidence of success follows its execution.

In hyposadias there are three fundamental principles in the surgical management: namely, the correction of curvature, the removal of the redundant prepuce, and the construction of a urethra. The first two of these are preliminary to the construction of a urethra. Great credit is due McIndoe<sup>8</sup> for applying the principles of inlying graft in the construction of a urethra. This method is applicable to any type of hypospadias, can be performed easily and without diversion of the urinary stream and is not attended by the disadvantages of fistula formation, deformities and long periods of hospitalization. Furthermore, the urethra can be placed in the glans penis in its normal anatomic position, which produces a more normal urethra than does any other method so far described.

The same principles of an inlying graft that are used in hypospadias can be applied with a high degree of success in the surgical treatment of congenital absence of the vagina. The mortality is reduced and the operation is done in one stage.

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## THE DIAGNOSIS OF MENINGITIS IN THE NEWBORN AND INFANT PERIODS\*

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The subject of meningitis in the newborn and infant periods merits separate discussion not only because the etiological and clinical manifestations of meningitis during these periods deviate considerably from the picture of meningitis in older individuals, but especially because the diagnosis, as a consequence, is often delayed or entirely missed. The delay in diagnosis may prove to be an unfortunate circumstance in the final outcome in certain cases of meningitis that respond to treatment, particularly meningitis due to meningococci and, as recently demonstrated with the use of sulfanilamide, meningitis due to hemolytic streptococci.

The incidence of meningitis, in general is comparatively low during the newborn period and early infancy. In considering the distribution of meningitis relative to age periods, Josephine Neale<sup>11</sup> reported an incidence of 2.8 per cent and Ravid<sup>13</sup> 6.6 per cent in infants under three months of age. Of great importance is the fact that organisms, ordinarily of little pathogenicity and rarely causing meningitis in other age groups, play an important rôle in the causation of meningitis in the neonatal and infant periods. Barron<sup>1</sup> in an analysis of thirty-nine cases of meningitis under three months of age, found fourteen to be due to *B. coli*, seven of which occurred in the newborn period. Of these thirty-nine cases of meningitis, nineteen were in newborns. Besides the seven cases of *B. coli* meningitis, six of these nineteen were due to streptococcus and staphylococcus, two to pneumococcus and one each to *B. mucosus capsulatus*, *B. lactis aërogenes*, and *B. pyocyaneus*. Craig<sup>5</sup> in a more recent clinical and pathological study of twenty-one cases of neonatal meningitis, found *B. coli* the responsible agent in approximately one-half of the cases. A number of other organisms have variously been reported as the cause of meningitis under one year of age, among which are micrococcus catarrhalis, Friedlander's bacillus, Koch-Weeks' bacillus, typhoid bacillus, the gonococcus, Gärtner's bacillus and an organism of the Salmonella group, organisms that rarely cause meningitis at any other age.

The present five leading forms of meningitis from a general statistical standpoint are, in the order of their frequency, as fol-

lows: meningococcus, tuberculous, pneumococcus, streptococcus and influenzal meningitis. Meningococcus meningitis is of relative infrequency under one year and has been found only rarely in the newborn period. Koplik<sup>8</sup> reported a case in a newborn in 1916. Brown and Silverthorne,<sup>3</sup> four years ago, reported a case in a three weeks old baby. In a series of 136 infants with meningococcus meningitis, reported by McLean and Caffey,<sup>10</sup> the youngest patient was twenty-three days old. Of 190 cases meningococcus meningitis in an eighteen months period reported by Borovsky<sup>2</sup> the youngest was three months old. Ravid<sup>13</sup> found that of eighty-eight cases of meningococcus meningitis occurring in a large metropolitan hospital in a period of four years, only 3 per cent were under three months. Josephine Neale,<sup>11</sup> in a larger series of 549 cases of meningococcus meningitis, likewise found 3 per cent occurring under three months of age.

Tuberculous meningitis is likewise found with relative infrequency under one year and with particular rarity under three months of age. Plischke,<sup>12</sup> recording a series of 1,305 cases of tuberculous meningitis, could not find a single case under two months of age. Out of 547 cases of tuberculous meningitis, Josephine Neale<sup>11</sup> found four instances, or 0.7 per cent, under three months of age.

Pneumococcus meningitis, while rare in the newborn period, occurs with increasing frequency in the latter part of infancy, due, undoubtedly, to its association with pneumococcus infection elsewhere in the body, particularly involving the ears and lungs. Karplus<sup>7</sup> found four cases of pneumococcus meningitis in the newborn up to 1927.

\*From the Northern Michigan Children's Clinic. Presented before the University of Michigan Pediatric and Infectious Disease Society, November 19, 1937.

Since that time four other cases have been found.<sup>9</sup>

*Streptococcus meningitis* is of relatively greater frequency among the cases of meningitis in the newborn and in infancy. Josephine Neale<sup>11</sup> found fifteen, or 30 per cent, of streptococcus meningitis cases occurring under twelve months of age, of which eight cases, or 16 per cent, occurred under three months of age.

Only 1 per cent of influenzal meningitis occurs in infants under three months of age.<sup>11,13</sup> A case of influenzal meningitis has been reported in the newborn.<sup>6</sup>

In regard to why meningitis is often caused by organisms ordinarily of little pathogenicity for older individuals, no proved explanation is available. It has been suggested, at least, that the development of meningitis due to organisms found commonly in the gastro-intestinal tract depends on a greater permeability of the intestinal mucosa in early infancy, coupled with an inherent low resistance to infections in general at this age.<sup>4</sup> The selectivity shown by these organisms for the meninges is not clearly understood. Craig,<sup>5</sup> in his study of neonatal meningitis, found morbid conditions of the skin and surface mucous membranes present in thirteen out of twenty-one cases and he believes that their presence, especially in premature infants, constitutes a definite risk of meningitis. Omphalitis, general sepsis, otitis media, and mastoiditis, are other recognized predisposing causes.

The clinical picture of meningitis in the newborn and infant periods is notable for the tendency of the classical signs of the disease to be absent, particularly in its early stages. More often than not, the condition is characterized by the existence of atypical features, the true nature of the disease being masked by symptoms common to non-meningitic conditions in infancy. While the onset may be sudden, it is often gradual and insidious. The symptoms at the onset may be of a more or less non-specific character, such as vomiting, diarrhea, fever, fretfulness, irritability, incessant crying, and anorexia. None of these symptoms, in themselves or in combination, point in a specific way to the presence of meningitis. The vomiting, when it is present at the outset, is apt to be non-projectile. A positive Kernig sign and nuchal rigidity, almost invariably present in older patients, are fre-

quently absent. Examination of the reflexes are, generally speaking, unreliable as diagnostic aids in infants. In the late or terminal stages, coincident with the development of marked intracranial pressure, projectile vomiting, the Kernig sign, and neck rigidity may become manifest in a definite manner. Occurring with fair frequency and most helpful in early diagnosis of meningitis in infancy, especially when associated with fever, are convulsions and bulging of the anterior fontanelle. While high fever is usually present, it may be of low grade and occasionally absent. A marked leukocytosis in the absence of fever is of significance in such instances.

In a period of five years (1932 to 1937) fourteen instances of meningitis, one year of age or under, were observed at the Clinic. Of these fourteen, three were meningococcus meningitis cases in four, eight and nine months old infants. Two were of tuberculous origin occurring in six and twelve months old infants. Pneumococcus meningitis occurred in five and seven months old infants. *Streptococcus meningitis* occurred in a nine day old infant and another in a two months old baby. One instance each of *B. coli*, *B. influenza* and *B. pyocyaneus* meningitis occurred in two, eight and twelve months old infants, respectively. One case was due to a mixed infection (*staphylococcus*, *streptococcus*, a large Gram-negative bacillus and Gram-positive diplococci). The final case was an instance of undetermined origin. Of these fourteen cases, twelve were in male and only two in female infants.

Apropos of the difficulties and consequent delay in the diagnosis of meningitis in infancy, it is of interest to record that, of twelve cases of meningitis, only in one instance was the correct diagnosis made before admission to the clinic. Of these twelve cases, seven were diagnosed on the day of admission to the hospital; three were diagnosed on the following day; the remaining two were diagnosed on the third and fifth days after admission, respectively. Of two cases of meningitis which developed during hospitalization, one was diagnosed on the day of its probable occurrence and the other two and one-half weeks after its estimated development.

The following summaries of seven cases of meningitis in the newborn and infant



periods are presented with the aim of bringing out the salient points dealing with the problems of diagnosis.

*Case 1.*—R. B., a male infant, was apparently well until the seventh day after birth. He was born at full term and the delivery was normal. The onset was characterized by irritability and fever (103° rectally). On the eighth day, the baby developed vomiting and diarrhea. Convulsions developed on the ninth day, the day of admission to the hospital. Coincident with the onset of the infant's illness, the mother was suffering from a puerperal infection. On the initial examination, the baby was having a generalized convulsion. He was very dehydrated and his rectal temperature was 106°. There was bulging of the anterior fontanelle. A questionable Kernig sign was present on the left. No neck rigidity was demonstrable. A spinal fluid specimen, obtained on admission, was cloudy and contained streptococci on direct smear. The baby died two hours after admission.

*Comment.*—The onset was characterized chiefly by symptoms of a gastro-intestinal disturbance. Convulsions, a more specific symptom, occurred on the last day of life. A bulging fontanelle led to a prompt performance of a lumbar puncture and to the diagnosis. The mother's puerperal infection undoubtedly had a direct causative relationship.

*Case 2.*—C. W., a three weeks' old female infant, was referred because of convulsions which began the day previous to admission. There were no other symptoms. The examination on admission revealed a dehydrated, convulsing infant. The anterior fontanelle was level with the scalp. Nuchal rigidity and the Kernig sign were absent. The temperature was normal. A leukocytosis of 35,450 with 77 per cent polymorphonuclear neutrophils was present, however. Vomiting and a bulging fontanelle appeared on the sixth day of hospitalization. Meningitis hitherto had not been suspected. A lumbar puncture performed on this day showed 640 cells, predominatingly polymorphonuclear neutrophils. Subsequent spinal fluid counts were as high as 7,230. Repeated cultures performed at the hospital laboratory and the laboratories of the Rockefeller Institute and the National Institute of Health of the U. S. Public Health Service were all negative. In spite of repeated lumbar, cistern and ventricular drainage, the patient developed progressive hydrocephalus and her course was slowly downhill, death taking place four months after admission.

*Comment.*—The only symptom present at the onset was convulsions. A bulging fontanelle, nuchal rigidity, a positive Kernig and even fever were all absent. A marked leukocytosis in the absence of all specific signs was significant. Careful search for the causative organism was unsuccessful and indicates that it was an uncommon etiological agent.

*Case 3.*—J. M., an eight weeks old male infant, was admitted with the history of onset four days

prior, characterized by fever and anorexia. Diarrhea developed two days before admission. The initial examination revealed a dehydrated infant. Temperature 102.6° rectally. The anterior fontanelle was depressed. Nuchal rigidity and the Kernig sign were absent. An acute right otitis media and a secondary anemia were present. Red blood cells, 2,640,000; hemoglobin, 57 per cent; white blood cells, 5,600. The infant's temperature persisted in spite of myringotomy. A lumbar puncture was performed on the second day because of unexplained fever and the spinal fluid count was 1,080 cells. Cultures showed the presence of *B. coli*. Cultures of the ear discharge, and of the urine later, likewise showed *B. coli*. The child's course was progressively downhill and he died on the seventh day of hospitalization.

*Comment.*—Fever, diarrhea, anorexia and secondary anemia, but no specific signs or symptoms, were present. A lumbar puncture, performed as a matter of diagnostic elimination, led to the diagnosis. It is probable that the infant had a *B. coli* sepsis, because of the presence of this organism in the urine and ear discharge.

*Case 4.*—G. W., a male infant of nine weeks, developed fever and anorexia two days prior to hospitalization. The child was born by breech delivery and was in a precarious condition for several days after birth. An intracranial hemorrhage was suspected. He was admitted to the clinic on a previous occasion at 5 weeks of age for malnutrition and was discharged three weeks later after a gain of one pound in weight. Initial examination on the last admission revealed a dehydrated baby with a fever of 103°, and a nasopharyngitis. Secondary anemia (red blood cells, 3,000,000; hemoglobin 60 per cent) was present. The anterior fontanelle was depressed. Nuchal rigidity and a positive Kernig were absent. Bilateral myringotomy was performed on the second day. Fever persisted. On the fourth day of hospitalization, the patient developed a subconjunctival hemorrhage and a bulging fontanelle. Vomiting, convulsions, a positive Kernig and nuchal rigidity were all absent. Spinal fluid was xanthochromatic and the count was 186 cells. Direct smear of the spinal fluid showed the presence of streptococci, staphylococci, large Gram-positive bacilli and Gram-positive diplococci. Exitus occurred 5 days after admission, preceded by a period of convulsions and projectile vomiting.

*Comment.*—This patient had a mixed type of meningitis. The exact time of development of his meningitis is difficult to determine. Intracranial hemorrhage, as evidenced by the history and the presence of xanthochromatic spinal fluid and otitis media may have been predisposing factors.

*Case 5.*—R. K., a male infant of four months, became ill ten days prior with fever of unexplained origin. He resisted handling. There had been no diarrhea, vomiting or convulsions. Examination on admission revealed dehydration, irritability, hyperesthesia and anemia. The anterior fontanelle was flush with the scalp. Red blood cells, 2,580,000; hemoglobin, 75 per cent; white blood cells, 14,550. No cause was found for the infant's fever. Lumbar puncture was performed on the second day for diagnostic exclusion and a count of 728 cells was found.



Direct smear showed Gram-negative diplococci. A total of 120,000 units of meningococcus antitoxin was administered over the next nine days, 64,000 units intravenously and 56,000 intramuscularly. Repeated small transfusions were given in addition. The patient's course was steadily downward and he died ten days after admission.

*Comment.*—This patient represents a case of meningococcus meningitis of insidious onset. Fever, irritability and hyperesthesia were the only symptoms present. No specific evidence had developed by the eleventh day of the disease, which would be unusual for meningococcus in older individuals. The delayed diagnosis was undoubtedly an important factor in the final outcome.

*Case 6.*—L. S., a male infant of eight months, developed fever five days prior to hospitalization. Vomiting began four days and convulsions one day prior to admission. The initial examination revealed a rectal temperature of 105 degrees. The infant was convulsing. A right internal strabismus was present. The deep reflexes were generally hyperactive and the anterior fontanelle was bulging. Nuchal rigidity and the Kernig sign were absent. Physical signs of bronchitis were present. Spinal fluid examination showed 2,250 cells with the presence of Gram-negative bacilli, morphologically characteristic of *B. influenza*, on direct smear. The infant expired on the second day of hospitalization, the entire duration of the disease being seven days.

*Comment.*—The significant clinical evidence of meningitis before lumbar puncture was the combination of convulsions and a bulging fontanelle in the presence of fever. Neck rigidity, the Kernig sign and other specific evidence were absent.

*Case 7.*—C. R., a twelve months old male infant, developed anorexia ten days prior to hospitalization. A progressive anemia ensued. On admission his rectal temperature was 106°. A mild icterus and a marked anemia were present. Red blood cells, 2,170,000; hemoglobin 20 per cent; white blood cells, 14,600. The infant was treated by means of repeated small transfusions, liver and iron. By the eighth day the blood picture had considerably improved (red blood cells, 3,040,000; hemoglobin, 42 per cent). A right otitis media developed at this time. Normal temperature for one week followed myringotomy. Otitis media, on the right side, recurred on the sixteenth day. From the sixteenth day of hospitalization, unexplained fever persisted for two and one-half weeks, when questionable nuchal rigidity developed. Vomiting, convulsions, a bulging fontanelle and a positive Kernig were all absent. Lumbar puncture revealed the presence of 4,100 cells. *B. pyocyaneus* was obtained on culture. The infant died six weeks after admission. Autopsy revealed the presence of a thick, greenish meningial exudate, especially marked over the left frontal area.

*Comment.*—Questionable nuchal rigidity and unexplained fever were the only clues before positive evidence was obtained by lumbar puncture. A recurrent otitis media

may have been a predisposing factor. *B. pyocyaneus* meningitis occurs infrequently.

### Summary

Meningitis in the newborn and infant periods often presents great difficulties in early diagnosis because of its tendency to assume an indefinite, atypical character. Etiological factors, in addition, differ considerably from the state of affairs in older age periods.

The onset of the disease in newborns and infants is often insidious and frequently ushered in by symptoms common to other infectious processes that occur within the first year, with the result that the true condition is apt to make itself manifest only in the late stages of the disease.

Such specific signs as nuchal rigidity and a positive Kernig are often not demonstrable in the early stages of disease. Instead, the condition may be masked by such non-specific symptoms as diarrhea, vomiting, irritability, otitis media, secondary anemia and unaccountable fever. Convulsions develop fairly frequently both early and late in the disease and in the presence of unexplained fever and leukocytosis constitute presumptive diagnostic evidence. The combination of fever, convulsions, and a bulging fontanelle should be considered positive evidence of meningitis until proven otherwise by examination of the spinal fluid.

Instances are met with in which unexplained fever exists as solitary evidence of meningitis and in which examination of the spinal fluid holds the final answer.

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# TRAUMATIC RUPTURE OF THE SPLEEN

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There is considerable variation in opinion relative to the frequency of injuries of the spleen in abdominal and thoracic trauma. One author is of the opinion that it is as high as 30 per cent. I cannot possibly believe that it is as high as this as in my own small experience, three years in general hospital and three years in general practice, I have seen only this one case.

Up to 1936 over 500 cases have been reported since the fifteenth century, Celsus being the first to describe this condition. Morgagni, in 1765, collected eighteen cases, the majority of which were pathological spleens. Berger, in reviewing cases up to 1902, showed that visceral injuries except bowel and bladder occurred in the following percentages: spleen 20 per cent, kidney 22 per cent, liver 37.5 per cent, all others, 20.5 per cent. Simpson reported a traumatic rupture in a new born, dropped on the floor in precipitate labor. In a series reported by Robitshek the following distribution in ages was found: 1-10, 23 cases; 11-20, 37 cases; 21-30, 29 cases; 31-40, 15 cases; 41-50, eight cases; 51-60, four cases. Out of 127 cases there were 104 males and 23 females.

The anatomy of the spleen is well understood and it is due to its pulp-like consistency, relatively thin capsule, and its suspension posteriorly beneath the diaphragm which makes it liable to rupture on the administration of a properly placed blow.

The symptoms are usually (1) history of trauma, (2) abdominal pain localized to the left hypochondrium or diffuse, depending on the peritoneal irritation present, (3) some difficulty in taking deep breaths, and (4) frequently, pain in the left shoulder. On examination the patient may or may not present signs and symptoms of shock. There is dullness in the left upper quadrant on percussion, and rigidity of the abdominal muscles on the left. Signs of external injury may or may not be present. The differential diagnosis in the male may be diaphragmatic hernia, ruptured liver and perforated bowel or stomach. In the female all of these, plus rupture of tubal gestation, twisted ovary and tube, and twisted pedicle of pelvic tumor are to be considered. These latter are mentioned because not infrequently they cause pain in the left shoulder. One must not forget that there are also cases of delayed symptoms, caused by (1) small hemorrhages in the spleen which eventually

lead to secondary rupture, (2) sub-capsular hemorrhage which becomes encysted, suppurative, or organized and ruptures into the peritoneal cavity with production of fatal hemorrhage, (3) continuous oozing from the time of accident. Dawson-Walker, 1931, reported a case in which the symptoms appeared fourteen days after the accident.

At the present time it is almost universally accepted that the treatment of ruptured spleen is surgical and in a vast majority of cases the spleen had best be removed. Other methods have been repair by suture or the use of a tamponade. If there has been considerable damage to the spleen or fragmentation has taken place it is certain that a tamponade or suturing is out of the question. If the fracture extends to the hilus either longitudinally or transversely and large mattress sutures have to be introduced it is obvious that a considerable area of infarction will ensue. Again, in the removal of a tamponade there is a question of whether secondary hemorrhage will occur. It may be argued, of course, that we are removing a large ductless gland whose function, even today, is only moderately well understood. Nevertheless, in the past, patients who have had their spleens removed apparently do not suffer any disease nor is their span of life materially reduced. In large intraperitoneal hemorrhages the unclotted blood can be scooped out into sterile dishes containing citrate solution, strained through gauze, and returned to the patient's circulation either during the operation or immediately postoperative. Saline-glucose, continuous glucose, and blood transfusion should be used.

## Case Report

Miss M. P., aged eighteen, was seen at 12:30 p. m. in her home. She complained of severe pain over her left lower ribs and a pain in the left shoulder. She said this came on at one o'clock



in the morning and became increasingly severe. She was somewhat nauseated, unable to urinate, and would not move in bed. Her past and family history were irrelevant.

The patient was an adolescent female who lay on her right side in bed with her knees well drawn up on her abdomen. She appeared to be in considerable pain. There was rigidity of the left rectus and girdle muscles. There seemed to be a localized point of tenderness over the eighth and ninth ribs in the mid-axillary line. Her pulse was 86, temperature 98 degrees, and blood pressure 116/70. The white blood count was 19,000, polymorphonuclears 87 per cent, lymphocytes 13 per cent.

The patient was hospitalized and consultation was obtained. Questioning of the patient at this time elicited no further history. The patient was catheterized and 600 c.c. of urine were obtained which was negative both chemically and microscopically. The patient was given small doses of morphine sulphate to control the pain and on the advice of the consultant surgery was deferred. The following morning her temperature was 99 degrees, pulse 104, and respirations 26. She complained then of some difficulty in breathing. By three o'clock in the afternoon the patient's temperature increased to 101 degrees, pulse 116, and her blood pressure was 90/50.

Surgery was considered imperative and one-half hour before the patient was operated on the parents elicited from the girl's chum that she had been in an automobile accident the same night as the onset of the symptoms. Apparently the car had side-swiped some trees, throwing her companion forcibly against her left side. The pre-operative diagnosis was made of ruptured abdominal viscus, probably spleen. Under a light ether anesthetic a left upper incision was made and upon opening the peritoneum blood gushed forth. An immediate exploration of the spleen was done. It was found ruptured, was delivered and, following an unsuccessful attempt at suturing, the tail of the pancreas was identified, the splenic pedicle was doubly clamped and the spleen removed. The pedicle was doubly ligated with number two chromicized catgut. A hasty inspection of the remainder of the abdominal cavity was done, splenic pedicle returned and the wound closed in layers without drainage. The patient was given immediately an intravenous injection of 10 per cent glucose, 1,000 c.c., followed by 1,500 c.c. of saline-glucose sub-pectorally. The following day 500 c.c. of citrated blood was given. The patient's condition improved rapidly following this. She made an uneventful convalescence except that it was necessary to catheterize her for four days.

On the tenth postoperative day a complete blood count showed: hemoglobin 50 per cent (Sahli), red blood count 3,100,000, white blood count 14,000, polymorphonuclears 80 per cent, lymphocytes 20 per cent. She returned home on the fourteenth day. On the fortieth day postoperative a recheck on the blood showed: hemoglobin 64 per cent, red blood count 4,780,000, white blood count, 8,800, and a smear showed more than the usual number of platelets. On the forty-third day postoperative she developed a severe pain in the left costo-vertebral region with a rise in temperature to 101 degrees; urine examination showed two plus albumin, an occasional red blood cell, and 80-100 pus cells to a high power microscopic field. A diagnosis of pyelonephritis was made. She was placed on ammonium chloride and hexamine and has been gradually improving since that time.

### Comment

The pathologist's report on this spleen was "a transverse fracture extending into

the hilum with early necrosis of almost one-half the spleen." This patient apparently had delayed symptoms in so far as her secondary shock was concerned. She was seen on the night of the injury by another physician, who prescribed heat to the site of the pain and the patient herself in concealing her history came near doing irreparable damage. The only external evidence of the injury in this case was a small area of ecchymosis over the olecranon process of the ulna.

### Conclusions

1. Rupture of the spleen must be considered in all abdominal injuries.
2. All cases of trauma to the head, throat and abdomen should be hospitalized for not less than twenty-four hours.
3. Splenectomy is the surgical procedure of choice where there is more than a minimum amount of damage, particularly if rupture to the hilum or fragmentation occurs. A tamponade is an invitation to a secondary hemorrhage in a patient who cannot tolerate further surgery.
4. Delayed symptoms are not uncommon.

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## THE ABUSE OF THE CAUTERY

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Marco Polo reported that the Chinese used the searing iron in the treatment of vaginal sloughs. The first recorded use of the cautery in definite cervical lesions was by Byrnes, in 1892. He used this form of treatment for cervical carcinomas. Hunner recommended the use of the cautery for benign cervical lesions, in 1906. But its real popularity dates from Dickinson's advocacy of the use of the fine nasal type of electric cautery for endocervicitis, in 1921. Since then the routine treatment of all kinds of cervical pathology by this method has become common practice in the office of most practitioners. As might be expected from the almost universal adoption of a standardized treatment, many errors have crept in. The method itself should not be condemned but its injudicious use in cases not adopted to such a form of treatment should be avoided.

An increasing percentage of patients are now presenting themselves for care upon whom the cautery has been used without relief and in some cases with positive damage. It is unfortunate that a procedure so valuable should be jeopardized by injudicious use. After studying these cases it is apparent that a warning note might well be sounded.

The cautery is being used erroneously in certain types of vaginal tract infection where there is little hope of amelioration of symptoms if the pathology is properly understood. Many cases of *Trichomonas* infections have been treated unsuccessfully with the cautery. It is obvious that this type of infection cannot be cured by such a method. The use of a hanging drop suitably prepared and the microscope will prevent such mistakes. The rarer mycelian infections will often be aggravated by the cautery and here, too, more careful attention given to the diagnosis of the particular type of infection will prevent error.

The degree of involvement is also a factor in the choice of treatment in cervicitis. The large hypertrophic cervix with multiple lacerations and ectropion is often so extensive that a cure of the condition by the cautery is practically an impossibility. In the cases where it is tried the extensive destruction of tissue may result in an eradication of the infection but the subsequent scar tissue contraction interferes so materially with adequate drainage that the remaining cervical glands are very easily reinfected.

Under this same heading comes that

group of early malignancies that can so easily be overlooked. Suspicious areas are cauterized rather than sections taken and a false sense of security replaces a helpful scientific curiosity. Needless to say, such a patient is not cured. Another type of case often treated ineffectively is the group in which the cervical infection overshadows a milder Skenitis and only the cervix is treated. Needless to say that in such instances the cervix becomes reinfected because the bugs are still present and the disease has not been cured. A small attention to this detail will increase the cures. This is also true of chronic Bartholinitis.

The cautery when injudiciously or improperly used in treating cervical lesions has resulted in positive damage. When early malignancies are so treated they are aggravated and the time lost in making a proper diagnosis may prevent the patient receiving the type of treatment that would result in a permanent cure. There is little excuse for such occurrences happening, but they do exist and are preventable with a little more attention to the need for an accurate diagnosis before treatment of any kind is instituted.

The treatment of old gonorrheal infections of Skene's, Bartholin and cervical glands is generally accepted as standard and is very effective providing the infection is limited and has not extended. But if the tubes are involved the cervix soon becomes reinfected and the treatment has been ineffectual. If the tubal infection is moderately active the cautery may act as an exciting force and the infection be lighted up, with subsequent virulent salpingitis, with abscess formation and even general peritonitis. Such a consequence of the injudicious use of the cautery is quite common and many such infections which if more moderately treated might have become healed have

been lighted up, with dire consequences. The citing of case histories bearing out this point is hardly necessary as they are so common that almost everyone doing a moderate volume of gynecological work has had personal experience with just this type of case.

Obstructive dysmenorrhea is a sequela of cervical cautery. It may vary in degree from the mild, painful contractions existing for an hour or two preceding the menstrual flow to those of marked degree with a long delayed menstruation and increasing pain extending over a period of days. The physical findings, as might be expected, show corresponding variation from a small amount of contraction of the external os to a completer occlusion of the entire cervical canal with a resultant hematometria. The cause of such an unfortunate outcome is primarily due to excessive tissue destruction and a failure to fully appreciate the importance of maintaining proper histologic structures to assure normal function.

Too often, in thinking of the organs of generation, the uterus is considered only as the repository of the developing embryo. We fail to adequately appreciate the histologic and anatomic differentiation of the uterus into two distinct parts each having contributive but still distinct functional duties. Essential differentiation between the corpus and the cervix is not made. The cervix serves as an exit for the endometrial debris, glandular secretions and waste material and for the entrance of the spermatozoa. But one of its primary functions is to serve as a barrier against infection entering the internal generative system. Its histologic structure with its glands, its folds of columnar epithelium and the moderate natural constrictions of the internal and external os fit the cervix for its protective job. That it will stand a tremendous amount of abuse is attested to by the extensive changes it undergoes in its attempt to maintain its function. Any therapeutic measures directed at pathology without regard to the maintenance of function can never be completely effective. The protective mechanism of the cervix and its canular duties must be maintained. The complete destruction of the cervical glands does interfere with its defense mechanism. True, in many cases most of the glandular structure may be infected and their removal a necessity, but it must be borne in mind that an organ so treated no longer presents as great a protec-

tion to the corpus. If, in the eradication of the glands nearer the external os, the first line of defense, too great an amount of the endocervical mucosa is destroyed, the external os may become constricted in the reparative process. Consequently the waste products are dammed up. The glands and tissue nearer the internal os are then subject to an increased pressure by the accumulation of waste products and suffer deterioration. A greater ultimate destruction occurs because inadequate drainage has resulted in an ineffectual cure.

How can some of these unfortunate results of the cautery be prevented? I believe that the cautery should not be used in cases where there are very marked eversion of the endocervix following extensive lacerations. The destruction that must be done to secure coaptation of the cervical tissue is so great that an unnecessary and unwarranted percentage of glandular tissue is lost, thus interfering with the normal defense mechanism of the cervix. True, cauterization or conization of cervixes can be done in a much shorter span of time and without much surgical ingenuity, but trachelorrhaphies have still a place in the armamentarium of the gynecologist. But he must be motivated by the interest to preserve function rather than by an overpowering desire to remove tissue in a wholesale manner.

The cautery is a very valuable means of therapy in the hands of the judicious. But there are many types and sizes of cautery and the destruction of tissue is directly in proportion to the size of the cautery tip used, the amount of tissue subjected to that heat and the relative amount of heat used. We would not think of using a thirty inch pipe wrench to tighten a  $\frac{3}{8}$ -inch nut, but we still see a cautery, capable of completely searing a one-inch block of hard wood, used for the eradication of a small nabothian cyst. Destruction and not restoration is the keynote that motivates the individual using it. All other things being equal, the finer the cautery tip that is used the less unwarranted damage will be done. In our experience the use of a fine wire cautery tip shaped on the principle of the Hayem tip used in electric conization has given extremely satisfactory results. In many cases where the infection is quite extensive and the linear scars to be made are too closely approximated, the treatment should be carried out in several different sittings, giving



ample time for the reparative process to proceed in the interim so that an adhesive agglutination of the canal with subsequent stenosis cannot occur. Interferences with the principles of drainage are just as erroneous in the treatment of cervical lesions as with any other.

Postoperative care is not to be overlooked. Wound healing here does not differ from wound healing any place else; proper drainage, possible infection, trauma, all play their part in the prevention of proper scar formation and results are often jeopardized by inadequate attention to minor details. Antiseptic douches properly carried out maintain cleanliness and promote free egress of the discharges. Occasional inspection with cleansing of the raw surface and removal of small sloughs will hasten and stimulate primary healing. The case is not complete until healing is complete and the operator is assured that the reparative process is finished and stenosis will not occur. The use of the Hegar dilator may be necessary to prevent a tendency to cicatricial contraction. If there is the slightest indica-

tion that cicatricial contraction is occurring, immediate dilation should be done and repeated once a month after each menstrual period for from three to six months. This treatment will usually prevent an embarrassing result.

#### Summary

The ease and popularity of cauterization of the cervix as a therapeutic measure in the treatment of cervical lesion is resulting in many abuses. Many of these abuses are reflected in failure to secure the expected results and casting reflection on the method rather than on poor judgment in its use. The abuses are of two general types. First, that of inadequacy due to a failure in making proper diagnosis prior to instituting the treatment and failure to select suitable remedial measure. Second, a failure to fully appreciate the importance of careful selection of types of apparatus used and appropriate after-care to assure the kind of result expected. Some constructive suggestions are offered that may aid in assuring the very fine results that can be obtained where the cautery is used under proper indications.

## COLLOIDAL ALUMINUM HYDROXIDE THERAPY IN UPPER GASTRO-INTESTINAL LESIONS\*

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The many benefits to be derived from the Sippy treatment of peptic ulcer cannot be denied. However, in certain instances the dangers of alkalosis, particularly in the elderly, secondary stimulation of gastric acid by the alkalies, the rather disagreeable taste of some alkali preparations and the quite definite idiosyncrasies of some patients to the alkalies, makes the use of some other antacid not only desirable but at times necessary. During the past two years we have been using as an antacid in the treatment of gastritis, gastro-duodenitis, and peptic ulcer preparations of colloidal aluminum hydroxide. Our results with the substance have brought out some interesting data.

Several clinicians have investigated various forms of aluminum in the treatment of gastro-intestinal conditions. B. B. Crohn<sup>2</sup> used aluminum hydroxide in the treatment of 20 peptic ulcers in 1929. Einsel, Adams and Myers<sup>3</sup> obtained good results from the use of the material in 101 of 110 cases of ulcer. Adams, Einsel and Myers<sup>1</sup> reported no significant change in serum chloride,

total base or carbon dioxide content of the blood of patients on aluminum hydroxide therapy. In February, 1936, Woldman and Rowland<sup>8</sup> described an apparatus for the continuous administration of dilute solutions of  $Al(OH)_3$  by intranasal tube direct into the stomach, and Woldman<sup>7</sup> has used the drip method as a treatment for hematemesis and melena. C. R. Jones<sup>5</sup> has recorded good results in the treatment of twenty-four proven cases of peptic ulcer by the colloidal aluminum hydroxide method,

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noting no disturbance in the serum calcium, total base or carbon dioxide content of the blood during the administration of the substance. Swalm<sup>6</sup> reports the treatment of 15 peptic ulcers with the same material with good result. Ivy et al<sup>4</sup> found no impairment in the health of animals to which aluminum compounds had been given in large amounts up to eight months and they review the literature on the toxicity of the substance. They consider the action of aluminum hydroxide to be one of buffering of the gastric acid rather than suppression of acid secretion.

We have used colloidal aluminum hydroxide in the treatment of twenty cases of peptic ulcer: one gastric ulcer and nineteen duodenal ulcers. Hyperacidity was present in all except the gastric ulcer, in which case the acid was normal. Three cases (Numbers 3, 5, and 20 of Table I) were confined to bed, seventeen were ambulant. Almost uniformly the patients reported quick relief from epigastric discomfort. In no case was there any untoward effect. Studies of the blood cytology and blood chemistry (non-protein nitrogen and sugar) and urine were made when the patients first came under treatment and at intervals of one month or less while they were taking the substance. All cases were given careful x-ray examination when first observed and in some cases during the course of treatment. Treatment extended over periods of three months to one year. Dosage usually began at 4 c.c. every hour in 120 c.c. of water and was reduced to 4 c.c. after each of the three main meals. One severe case of hemorrhaging duodenal ulcer was treated with the drip method, using the collapsible latex intranasal tube, with rather dramatic result. The preparations† used in this series of cases were white gelatinous liquids, slightly astringent and definitely demulcent. When diluted with water most of the astringency was lost and they became fairly palatable. They contained approximately 5 per cent aluminum hydroxide in plain water or in 0.6 per cent sodium chloride solution.

Selected case reports are presented to show the results obtained.

*Case 1.*—Miss M. L., a white woman, forty-one years of age, who does housework at home and does dressmaking at times, complained of indiges-

tion, pain in the right side of the upper abdomen, gas on the stomach, and constipation. Symptoms had been present in severe form seven weeks. Epigastric distress came on one or two hours after meals and was at first relieved by food and by soda but later not so relieved. She had had an active pulmonary tuberculosis at the age of thirty-two which was treated at home and in a sanitarium and which is now arrested. Appendectomy for chronic appendicitis had been performed at the age of thirty-five.

The patient when first seen one year ago weighed 109 pounds (49.5K) and was anemic. Tonsil tags remained from two previous tonsillectomies. One tooth was carious. The lungs were clear, the heart sounds normal, and the blood pressure was 120-70. Tenderness to moderate finger tip pressure was elicited in the epigastrium to the right of mid-line and in the right lower quadrant over the appendectomy scar. Rectal examination revealed inflamed external and internal hemorrhoids which bled easily. Hemoglobin was 102 per cent (Sahli). Erythrocytes numbered 4.08 million. Leukocytes totalled 6,150 with 71 polymorphonuclears and 29 large lymphocytes. Urinalysis was negative. The basal metabolism was -4. In the stool, no blood, ova or parasites were found. Gastric function studies revealed 110 c.c. of fasting juice with free hydrochloric acid of 28 units. After the bread and water meal the free hydrochloric acid rose to 25 units at 105 minutes. Fifty-five c.c. of material was removed from the stomach two hours after the administration of the test meal. X-ray studies revealed a constant deformity of the duodenum typical of an ulcer with a small amount of barium retained in the stomach at the end of four hours. Cholecystographic studies showed no abnormality. The cardiogram was normal.

The patient was placed on Sippy diet with alkaline powders six times daily. She was at first relieved but after two weeks in spite of close adherence to the treatment the epigastric pain recurred. Two months later the pain was coming on during the day and almost every night about 1 a. m. Gastric analysis at this time showed a small amount of retention of the fasting content with free HCl of 70 units 90 minutes after the test meal was given. The patient was then started on a compound of colloidal aluminum hydroxide and aluminum silicate. Symptomatic relief was prompt but not complete. Two weeks later a concentrated form of colloidal aluminum hydroxide (approximately 5 per cent) was given and relief was complete. In addition to the aluminum hydroxide, sedatives such as phenobarbital, and laxatives such as cascara, were administered. The diet was bland, high in carbohydrates, vitamins and minerals.

Blood cell studies and blood sugar, nitrogen, and chloride determinations were made at the beginning of treatment and once a month thereafter and showed no deviation from normal. X-ray studies after six months of colloidal aluminum hydroxide treatment revealed deformity of the duodenal bulb such as is seen in duodenal ulcer but no gastric retention of barium at the end of four hours.

The patient has after over one year of observation gained seven pounds and has a good healthy appearance. An occasional twinge of discomfort in the upper abdomen seems to be associated with nervous tension consequent to her poor financial status.

*Comment.*—Modified Sippy treatment apparently well carried out did not permanently relieve this patient of her ulcer symptoms. Colloidal aluminum hydroxide produced permanent relief.

†Kao-Magma and Amphojel (Wyeth) and Creamalin (Cleveland Chemical Associates).



*Case 2.*—Mr. R. C., a white man, aged sixty-eight, unemployed, complained of pain in the right side of the upper abdomen coming on at various intervals after meals and during the night. Pains were quite severe, sufficient at times to force him to remain quiet in bed. These pains had been coming on for about four months. He had been constipated for five years, taking Epsom salts two or three times a week. There was dyspnea on exertion and deafness. There was no history of previous gastrointestinal disturbance.

The patient was a tall elderly male weighing 176 pounds (80K). The teeth were absent, being replaced by dentures. Nose and throat appeared normal. The lungs were clear. There was a soft systolic murmur at the apex but no great enlargement of the heart. Blood pressure was 160-90. There was tenderness in the epigastrium of moderate intensity to finger-tip pressure. No tumors were made out. Hemoglobin was 90 per cent and erythrocytes 4.26 million. White cells numbered 7,900 with normal distribution. The urine was normal and the stool contained no occult blood, ova or parasites. The Kahn was negative and blood chemistry normal. Gastric analysis showed no retention of the fasting content but a high fasting free HCl: 50 units. After the bread and water meal the free acid rose to 74 units at 105 and 120 minutes. X-ray studies revealed a duodenal ulcer with no material gastric retention.

Due to the patient's age it was deemed advisable to give one of the non-absorbable antacids and so avoid alkalosis. Aluminum hydroxide in the colloidal form was given along with phenobarbital and cascara and mineral oil. The diet was bland, high in carbohydrates, minerals and vitamins.

Relief of symptoms was dramatic. Within twenty-four hours the pain had ceased and he had no recurrence during the succeeding eight months. Monthly check-up of the blood cytology and chemistry showed no deviation from normal. The patient gained seven pounds. Control of constipation presented the only real problem in this case. Cessation of the colloidal aluminum hydroxide treatment after eight months has not been followed by recurrence of pain.

*Comment.*—Administration of colloidal aluminum hydroxide to this elderly patient with active duodenal ulcer and hyperacidity produced prompt relief without development of alkalosis. Constipation was difficult to control. This exemplifies one of the disadvantages of the treatment.

*Case 3.*—F. O., a white man of thirty-six years, was a worker on an assembly line in an automobile factory on the night shift. Following a severe attack of purulent para-nasal sinusitis complicated by hay fever the patient developed pain in the upper abdomen with belching of gas and constipation. Physical examination revealed a thin, pale young man of a nervous high-strung type. There was a heavy yellow post-nasal discharge. The teeth were in good repair and the tonsils had been cleanly removed. The lungs were clear. There was a rough systolic murmur referred to the left axilla. Tenderness was noted on light pressure of the epigastrium. The pelvic colon was easily palpated as a tender rope-like structure. Urinalysis was negative as was the Kahn test. Hemoglobin was 70 per cent (Sahli). Erythrocytes totalled 3,620,000 with normal morphology. Leukocytes were 7,200; polymorphonuclears 68 per cent, small lymphocytes 28 per cent, large lymphocytes 2 per cent, basophils 1

per cent and eosinophils 1 per cent. Gastric analysis when first observed showed some retention of the fasting content with absence of free hydrochloric acid. After the bread and water meal the acid rose to 37 units at 120 minutes. On microscopic examination of the fasting content we found leukocytes, red blood cells, squamous epithelial cells and gastric cells in large numbers. A diagnosis of chronic gastritis was made. X-ray examination produced evidence of a mild degree of hypertrophy of the gastric mucosa with no evidence of ulcer in the stomach or duodenum.

The patient was placed on Sippy regime but continued to work nights. He was at first relieved but in six weeks suffered a recurrence of epigastric pain, more severe and more definitely localized. Gastric analysis at this time found the free HCl at 110 units two hours after the bread and water meal was taken. X-ray now showed a definite duodenal ulcer. Strict Sippy regime was again instituted and the patient put to bed. Shortly thereafter he began to be nauseated by the Sippy powders and was changed to colloidal aluminum hydroxide. Relief from pain was prompt and he was no longer nauseated. He gained weight, improved in appearance and lost much of his nervousness. The aluminum hydroxide was continued in decreasing amounts for six months with relief from symptoms and with no untoward effect. Regulation of the bowels was obtained with the use of bile salts, cascara, mineral oil and later bulk producing materials.

*Comment.*—A case of chronic gastritis which developed a duodenal ulcer. Relief on Sippy regime while working nights lasted only six weeks. Relief was again obtained with the use of Sippy regime with the patient on bed rest. Nausea developed necessitating change of therapy. Colloidal aluminum hydroxide relieved the pain without nausea, but laxatives were required to control bowel action.

*Case 4.*—W. S., a white man of thirty years, operator of a punch press in an automobile factory, had had fullness in the epigastrium with the sensation of gas crowding his heart for three months. The distress came on thirty to sixty minutes after meals and gradually wore off an hour or so later. Food and soda relieved the discomfort for a time. There had been a loss of 10 pounds of weight in the three months. Constipation was of eight years' duration. The patient had been more or less nervous all his life. Physical examination revealed a thin, high-strung type of man. Nose and throat were inflamed and there were a few carious teeth. The tongue was badly coated and the breath foul. Lungs and heart sounds were normal. The blood pressure was 110-70. There was a definite finger point tenderness of the epigastrium in mid-line and moderate tenderness of both lower quadrants. Reflexes were equal but increased. Rectal examination revealed internal hemorrhoids. The erythrocytes numbered 3.65 million with 88 per cent hemoglobin. Leukocytes were 6,300 with polymorphonuclears 69 per cent, lymphocytes 28 per cent, eosinophils 2 per cent and basophils 1 per cent. The urine was normal. The blood Wassermann was negative. Stool examination showed no blood, ova or parasites. Gastric function studies revealed evidence of retention of the fasting content with a fasting free hydrochloric acid of 42 units. After the bread and water meal the free HCl rose to 70 units at the end of ninety minutes. Sixty-four

## COLLOIDAL ALUMINUM HYDROXIDE—CONNELLY

TABLE I. REPORT OF TWENTY CASES OF PEPTIC ULCER TREATED WITH COLLOIDAL ALUMINUM HYDROXIDE

Case No.	Patient	Sex	Age	Duration of Symptoms	Relief of Symptoms	Relief Began (in days)	Permanent Relief	While Under Treatment			
								Constipation	Alkalosis (Clinical)	Epigastric Distress	Nausea
1	M.L.	F	41	7 wk.	Yes	1	Yes	Yes	No	No	No
2	R.C.	M	68	4 mo.	Yes	1	Yes	Yes	No	No	No
3	F.O.	M	36	6 mo.	Yes	1	Yes	Yes	No	No	No
4	W.S.	M	30	3 mo.	Yes	1	No	Yes	No	No	No
5	H.D.	M	26	5 yr.	Yes	1	Yes	Yes	No	No	No
6	B.W.	F	24	4 mo.	Yes	1	Yes	No	No	No	No
7	L.W.	F	37	2 yr.	Yes	2	No	No	No	No	No
8	F.R.	M	53	2 wk.	Yes	1	Yes	Yes	No	No	No
9	W.W.	M	39	1 yr.	Yes	1	No	No	No	Yes	Yes
10	G.M.	M	33	6 mo.	Yes	1	Yes	Yes	No	No	No
11	M.P.	F	29	9 mo.	Yes	2	Yes	Yes	No	No	No
12	G.B.	M	38	2 yr.	Yes	3	Yes	Yes	No	No	No
13	G.F.	M	49	6 yr.	Yes	2	Yes	No	No	No	No
14	T.M.	M	28	3 mo.	Yes	1	Yes	Yes	No	No	No
15	R.F.	F	24	6 mo.	Yes	2	Yes	Yes	No	No	No
16	G.F.	M	36	1 yr.	Yes	1	Yes	No	No	No	No
17	S.K.	M	28	6 mo.	Yes	1	Yes	Yes	No	No	No
18	M.M.	M	49	14 yr.	Yes	1	Yes	Yes	No	No	No
19	A.T.	M	37	2 yr.	Yes	1	No	Yes	No	No	No
20	F.G.*	M	25	6 mo.	Yes	1	Yes	Yes	No	No	No

\*Gastric Ulcer.

c.c. of gastric content remained in the stomach after two hours, indicating some delay in emptying. X-ray revealed very coarse rugal pattern, particularly in the pars pylorica, marked pylorospasm, narrowing of the pyloric orifice and deformity of the duodenal bulb. There was irregularity in outline of the gastric side of the pyloric ring.

The patient was placed on colloidal aluminum hydroxide therapy with 4 ounces of a milk and cream mixture every hour. Relief from pain was almost immediate. Two weeks later following a hurried trip to his sick mother's bedside he suffered a recurrence of pain. Rest in bed three days with a return to his dietary and medical regime again relieved the distress. Radiograph taken four weeks after the first observation showed no gastric retention and only slight deformity of the duodenal bulb. The irregularity of the gastric and duodenal sides of the pyloric ring was greatly diminished.

Seven months later the patient was free of symptoms except for a burning sensation in the epigastrium noticed on the two mornings he was scheduled for examination. X-ray showed no demonstrable active ulcer. The deformity of the duodenal bulb remained but was considered to be the result of scar tissue. The rugae were still prominent in the pyloric end of the stomach but there was no demonstrable neoplasm.

*Comment.*—A case of duodenal ulcer with gastric retention in a highly nervous individual which responded to colloidal aluminum hydroxide therapy. He was free of

true ulcer symptoms seven months after treatment was instituted.

*Case 5.*—H. D., a white man, aged twenty-six, employed on an assembly line in an automobile factory on the night shift. He had had a perforated appendix at the age of sixteen, with removal of the appendix four months afterward. At the age of twenty-one he began to have indigestion coming on sixty to ninety minutes after meals. The distress was relieved by food and by soda. Two weeks before admission to the hospital he had an attack of severe epigastric pain, sufficient to "double him up." The attack was considered by his attending physician to be a small perforation which was sealed off spontaneously and did not require operation. Following this attack the periodic pain became more severe and at times was felt through to the lower thoracic back. On admission to the hospital he was placed on true Sippy regime. X-ray revealed deformity of the duodenal bulb typical of an ulcer and palpation directed over the bulb elicited considerable discomfort. The patient responded to alkaline therapy only after four days. After that his progress was good. He was discharged from the hospital on a modified ulcer diet and Sippy powders after thirty days of treatment.

The patient failed to continue his treatment as directed, had recurrence of his epigastric pain three days after leaving the hospital and ten days later returned to the hospital. In spite of alkaline medication and restricted diet he continued to have pain in the upper abdomen and nausea. After three weeks some improvement was observed and he was



## COLLOIDAL ALUMINUM HYDROXIDE—CONNELLY

TABLE II. REPORT OF TWENTY CASES OF PEPTIC ULCER TREATED WITH ABSORBABLE ALKALIES

Case No.	Patient	Sex	Age	Duration of Symptoms	Relief of Symptoms	Relief Began (in days)	Permanent Relief	While Under Treatment			
								Constipation	Alkalosis (Clinical)	Epigastric Distress	Nausea
1	M.A.	F	24	2 yr.	Yes	1	No	No	No	No	No
2	P.P.	M	55	2 yr.	No	.	.	No	No	Yes	Yes
3	A.S.	F	46	15 yr.	No	.	.	Yes	No	Yes	No
4	M.J.	F	52	2 yr.	Yes	2	No	No	No	Yes	No
5	N.E.	M	41	5 yr.	Yes	2	Yes	No	No	No	No
6	J.V.	M	46	3 mo.	Yes	17	Yes	No	No	Yes	No
7	G.M.	M	23	6 mo.	Yes	1	No	No	No	Yes	Yes
8	M.K.	F	39	3 mo.	Yes	3	No	No	No	No	No
9	E.B.	F	36	1 yr.	Yes	2	Yes	No	No	No	No
10	M.L.	F	41	2 mo.	Yes	5	No	No	No	No	No
11	M.C.	F	54	6 mo.	No	.	No	Yes	No	Yes	Yes
12	A.M.	M	58	3 mo.	Yes	2	No	No	No	No	No
13	H.D.	M	26	6 mo.	Yes	2	Yes	No	No	No	No
14	L.B.	F	25	6 yr.	Yes	3	No	Yes	No	No	No
15	J.H.	M	26	2 yr.	Yes	1	No	No	No	No	No
16	J.F.	M	48	6 yr.	Yes	2	Yes	No	No	No	No
17	F.T.	M	26	6 mo.	Yes	1	Yes	No	No	No	No
18	G.M.	M	29	5 wk.	Yes	2	Yes	No	No	No	No
19	E.S.	F	38	5 mo.	Yes	2	Yes	No	No	No	No
20	J.S.*	M	54	4 yr.	Yes	2	Yes	No	No	No	No

\*Gastric Ulcer.

sent to a convalescent home. Two weeks later while he was a bed patient in this well supervised convalescent home he had a severe gastro-intestinal hemorrhage and was readmitted to the hospital. Forty-eight hours after the hemorrhage he was placed on intranasal drip of colloidal aluminum hydroxide. Sedatives were administered and a modified ulcer diet given. Relief from symptoms occurred within twelve hours. The drip treatment was continued for fourteen days. He was then given colloidal aluminum hydroxide by mouth and his diet was increased. Five months have now elapsed since the hemorrhage. The patient has had no recurrence of his symptoms. He has gained twelve pounds in weight, looks and feels well and has been working at his former occupation on a day shift one month. The patient is at present taking 4 c.c. of colloidal aluminum hydroxide, three times daily.

*Comment.*—A case of hemorrhaging duodenal ulcer of severe type which did not respond to Sippy treatment and which did well on the intranasal drip method of administration of colloidal aluminum hydroxide.

In evaluating the colloidal aluminum hydroxide treatment of upper gastro-intestinal lesions we have considered (1) time required for relief from symptoms; (2)

permanence of relief from symptoms; (3) nausea; (4) deleterious constitutional effects; and (5) constipation. As a control group we have used an equal number of cases of peptic ulcer, 1 gastric and 19 duodenal, in which diagnosis was confirmed by x-ray examination and in which the bland diet-absorbable alkali method of treatment was used. We hesitate to present statistics on such a small group of cases but feel that the data should be made available to support our conclusions. Table I presents twenty cases treated with colloidal aluminum hydroxide; Table II presents twenty cases treated with diet and alkali.

The average time for relief of symptoms with the colloidal aluminum hydroxide method was one day; with alkali method two days.

Permanence of relief from symptoms: relief was permanent in sixteen (80 per cent) of the cases treated with aluminum and nine (45 per cent) of those treated with alkali.

Nausea was reported in one case (5 per

cent) treated with colloidal aluminum hydroxide and by three cases (15 per cent) of those on absorbable alkalies.

No deleterious effect was seen in those cases taking colloidal aluminum hydroxide whereas of those patients on absorbable alkali six (30 per cent) reported epigastric distress. With our present methods of determining the presence of alkalosis we find only those cases with gross changes in the blood pH. It may well be that some cases which do not do well on absorbable alkaline therapy have mild alkalosis producing anorexia, weakness and malaise. It may be that there are disturbances in the body chemistry other than alkalosis which produce these symptoms.

Constipation was noted in fifteen cases (75 per cent) of those on the aluminum hydroxide and in three cases (15 per cent) of those on alkaline therapy.

### Comment

In colloidal aluminum hydroxide we have an antacid which serves as a buffer of hydrochloric acid and so reduces the irritating action of the gastric secretion on the injured mucosa of the stomach and duodenum. It may also inhibit digestion of a blood clot over a hemorrhaging ulcer. The substance is fairly palatable and does not ordinarily produce nausea. Its use even over as long a period as one year seems to produce no harmful action on blood cytology or chemistry.

### Summary

1. Colloidal aluminum hydroxide proved to be an antacid of considerable value in the treatment of twenty peptic ulcers; one gastric and nineteen duodenal.

2. Comparison of results of colloidal aluminum hydroxide therapy with alkali therapy seems to give an advantage to aluminum hydroxide.

3. The only serious drawback noted was the fact that colloidal aluminum hydroxide has no laxative action and in patients on a liquid diet or in patients at rest in bed some other substance (such as cascara sagrada) must be used to promote proper evacuation of the bowel.

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## A METHOD OF CONTROLLING THE IMMEDIATE SYSTEMIC POLLEN REACTION\*

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Since the advent of pollen therapy the prevention and control of the systemic reaction has engaged the constant study and attention of those interested in this field of medicine. To date in spite of the ingenious methods devised by various workers, there remains a certain amount of risk involved in the administration of pollen extracts. It is comforting, however, to note that in the past few years there has been a gradual decline in the incidence of these reactions.

Many of the early workers in the field of allergy previous to the epinephrine era experienced many constitutional reactions, but nothing is recorded relative to the manner in which they were handled. Cook<sup>1</sup> was

among the first to apply the tourniquet, and use epinephrine for this purpose. Since then there has been various modifications of this method in the prevention and control of such reactions.

\*Read before the Michigan Allergy Society, November 23, 1937.



Duke's<sup>2</sup> method consists of the application of the tourniquet above and prior to the injection, the tourniquet being removed and replaced at intervals for fifteen minutes following the injection. Ephedrine and epinephrine are mixed with the extract for the purpose of preventing rapid dissemination of the antigen. A physiological salt solution is then added to bring the volume up to 1 cc. .01 cc. of the extract is then injected subcuticularly in order to determine whether the needle is in the vein before injecting the entire amount of the solution.

Insley,<sup>3</sup> Rice,<sup>4</sup> and Waldbott<sup>6</sup> advocate similar technique.

Other measures have been used as a means in the prevention of systemic reactions, such as the administration of Epinephrine with pollen extracts without the use of the tourniquet. This method is ineffective in the severe type of reaction, and has not proven satisfactory due to the fact that the epinephrine is generally used in too small a dosage in combination with the pollen extract to prevent severe constitutional reactions of the immediate or delayed type.

The principal fault with this method is that the small quantity of epinephrine used only tends to delay the absorption of pollen until the patient reaches home where he will develop his reaction. Then too, patients frequently complain of the undesirable physiological effects received from this product.

Another measure sometimes used is the oral administration of ephedrin either before or after pollen injections. Ephedrin used in this manner may prove helpful in the prevention of mild reactions.

To the physician who is not familiar with the hazards sometimes accidentally associated with pollen therapy, and who is seeing the occasional hay fever patient should be impressed with the fact that the prevention of the constitutional reaction is in a large measure directly under his own control, and it can be safely stated that unless he familiarizes himself with certain essential and fundamental facts, in addition to a definite technique in the administration of pollen extracts he may expect to be confronted with some stormy and unhappy experiences.

Recent observation reveals that too little time and study has been devoted to the prevention of the systemic reaction. Several physicians who have been interviewed relative to administration of pollens informed the writer that as a rule they have practical-

ly disregarded the possibility of these reactions because they felt that in the event of such experiences they could always resort to the use of epinephrine to combat the more severe type of reaction. It is true that this drug will relieve the majority of reactions; however, there are instances which have been reported where epinephrine failed to revive the patient in allergic shock. One such has been reported by R. N. Lamson.<sup>5</sup>

A man, thirty-four years of age, sensitive to several pollens, was receiving co-seasonal treatments with Bermuda grass. A series of fifteen doses, having been received in a period of twenty-two days, had been worked up to a dosage of 0.10 c.c. of 1:100 dilution. There was apparently no immediate trouble from this dosage, but the patient declared that the treatment had made him "nervous," and that he did not sleep so well following the injection. On the following day he was given one-half of the previous dose (0.05 c.c.) of the 1:100 dilution. Immediately following the injection the patient walked to a chair. His face suddenly flushed; athetoid movements of the hands, arms, and legs followed, also marked dyspnea of an inspiratory type developed. Although he was instantly given 2 c.c. of epinephrine, and artificial respiration, he died. This reaction was apparently due to over dosage, or an accidental intravenous injection of the pollen extract.

Among physicians interviewed some have stated that they have permitted their nurses to administer a large part of their pollen treatments. This is perfectly satisfactory provided it is done under the physician's supervision. In one instance a nurse administered a dose of pollen extract to a patient during the absence of the physician. Immediately following the injection the patient developed a constitutional reaction, and died in anaphylactic shock. This case was not reported in the literature, and further information was not obtained regarding detail. The majority of nurses are capable of giving such treatment, but few are familiar with the potential dangers involved in the administration of large doses of pollen extracts to hypersensitive individuals.

In another case a patient was permitted to give her own hypodermic injections. Such a plan is to be condemned, not only because of the possible danger involved, but because it tends to self-medication in other forms of therapy.

### Symptoms of Constitutional Reaction

The constitutional reaction is considered as immediate, or delayed, depending upon the time of its appearance following the injection of the antigen. In the immediate type of reaction in which the pollen extract

has accidentally found its way into the circulation the reaction may take place instantly, or within a few minutes following the injection.

Reactions appearing one hour or more following the injection are considered as delayed reactions. As the immediate reaction has proven to be the most serious and alarming, this paper is devoted particularly to its study and prevention.

Almost any tissue in the body may be involved in these reactions. The skin and respiratory tract are most frequently affected. The skin response may vary from a simple itching of the palms of the hands to a massive swelling of the face and hands. Sneezing and coughing are most frequent symptoms, and if they are not interrupted may be a forerunner of a violent and severe attack of asthma. Other symptoms encountered are: headache, hives, abdominal pain, uterine cramps and bleeding; also generalized pruritus; nausea, vomiting, and shock have been observed.

#### Some Important Precautions for Preventing Reactions

1. Urge all patients to appear early for preseasonal treatment in an endeavor to prevent crowding of dosage, and in order to give adequate treatment before the onset of the season.

2. Care should be exercised in determining the tolerance of the patient to the specific pollen.

3. Caution should be observed in changing from old to fresh pollen extracts; also in stepping up the dosage from weak to strong dilutions without inconvenience to the patient.

4. One should have an intimate knowledge of the patient's local reaction to his previous treatment; this is positively a criterion as to the subsequent dosage. Doses should never be increased in the event of a large local reaction from previous injections.

5. A careful guidance of the patient through the hay fever season should result in the avoidance of secondary factors; particular attention should be paid to such items as foods to which he may be sensitive, and to inhalents other than pollen.

6. Avoid over exertion, or exercise following injections.

7. Discourage self-administration of pollen extracts.

8. Carefully avoid such mistakes as picking up the wrong bottle, and thereby administering the improper dilutions and extracts. Also by avoiding errors of estimating improper dosage.

9. Avoiding forceful and rapid hypodermic injections is of prime importance.

It is generally excepted that over-dosage and accidental penetration of blood vessels are responsible for a majority of the immediate reactions. Waldbott and Asher<sup>7</sup> state that injected material may often reach the circulation by back-seepage due to venous puncture. In the treatment of a large number of hay fever patients it has been my impression that back seepage may under certain conditions be aided by a too rapid introduction of the material into the tissues. It is entirely plausible that in the event of a nicked or partially lacerated vessel that it could further be torn or possibly ruptured, due to a forceful and rapid introduction of the solutions.

Conscious of the possible danger associated in the sudden introduction of pollen extracts as subcutaneous injections, I have adopted the following technique, and have described it as the "slow injection method."

I have devised an apparatus which consists of a rubber tourniquet, twenty-four inches in length, and one and one half inches in width. Throughout the length of the tourniquet, at one half inch intervals, perforations have been made for the purpose of adjusting the device to any size arm. About two inches from one end of the tourniquet is anchored a metal, adjustable bracket that can be moved about in a two-inch radius on each side of the arm. At the distal end of this is attached a metal spring clamp for the purpose of holding a tuberculin syringe. The tourniquet serves three purposes: First, for the momentary compression of the arm preliminary to the injection. This is for the purpose of distending all veins of the arm and, therefore, facilitating the withdrawal of blood into the syringe in the event of an accidental venous puncture. Second, it serves as a support for the syringe, clamp, and holder. Third, as the tourniquet is kept comfortably adjusted to the arm during the injection of the extract, it may be conveniently used in the event of an immediate reaction.



### Technic in Administering Pollen Extracts

The apparatus is adjusted to the upper part of the arm, and the tourniquet is tightened for a minute. The needle is then introduced subcutaneously at the outer aspects of the arm, one and one half inches below

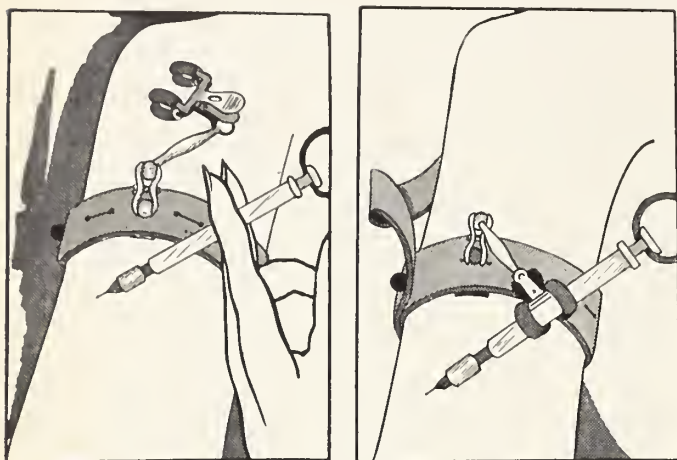


Fig. 1. (left) Application of tourniquet for distention of arm veins and withdrawal of piston preliminary to injection.

Fig. 2. (right) Syringe held in position for slow subcutaneous injection.

the tourniquet (Fig. 1). The piston is withdrawn slowly once or twice; if there is no evidence of blood the tourniquet is released enough to permit venous flow, but it is retained on the arm sufficiently tight to support the apparatus for holding the syringe. The syringe is then clamped and held in position (Fig. 2) while a drop, or as small a quantity of the antigen as possible, is injected at minute intervals for five minutes. If there is no sign of reaction, the balance of the material is carefully injected. At the end of six minutes if there are no signs of general reaction the syringe and apparatus are removed and treatment completed.

During the time of injections all patients are instructed to report any subjective symptoms that may develop; such as itching of the palms, generalized pruritus, tingling of the tongue, etc. All patients should remain in the office at least fifteen minutes following the treatments.

The slow injection method was used by the writer during the 1937 hay fever season in the treatment of 188 patients with seasonal hay fever. A survey of this group reveals very few reactions in comparison to reactions experienced in the treatment of a large number of hay fever patients in previous years. The few reactions observed were of a mild nature, and easily controlled.

The most severe reaction encountered, including its management, is briefly described as follows:

Mrs. R. H., aged fifty-two years, with seasonal hay fever, and asthma of thirty years duration, was receiving her first year of preseasonal treatment. Formerly she had spent the summer in northern Michigan for the purpose of avoiding the ragweed pollen to which she was extremely sensitive. In addition to a marked sensitivity to the short and giant ragweed she showed a multiple sensitivity to many foods, and miscellaneous substances. On May 18 she was receiving an injection containing 1,500 units of mixed ragweed; the preparation was being administered slowly, as all previous injections. Suddenly she asked what kind of a treatment she was receiving; and she was told that it was the usual ragweed material. She complained of a marked tingling of the tongue, numbness of the lips, and itching of the palms. The needle was immediately withdrawn, and five minims of adrenalin was injected in the other arm. The tourniquet which was on the arm, retaining the apparatus, was immediately constricted and kept on the arm for a period of fifteen minutes; it being released at two minute intervals. Five minims of epinephrine was repeated in ten minutes as a precautionary measure. Within 15 minutes of the onset of the reaction the patient was feeling perfectly normal.

In this instance by injecting only a minute portion of the extract, and omitting the remainder of her dosage, the possibility of a severe general reaction was prevented.

### Advantages of Method

It affords ease and simplicity in administration of the treatment; thus it may be used with confidence by the general practitioner inexperienced in pollen therapy.

The slow injection method makes treatment much less painful, and it also tends to eliminate unnecessary medications, such as the epinephrine combination mixture with the injections. It prevents oozing and loss of extracts at injection sites. Also the immediate local reaction at the site of the injection is seldom encountered. A physician with a heavy allergy practice may treat as many as five patients simultaneously, provided all patients are under his constant observation and supervision.

### Summary

A frequent cause of systemic reaction is the force and rapidity with which hypodermic injections are often given; this resulting in vessel injury and immediate introduction of pollen extracts into the blood stream. By closely observing the patient during the process of inoculation, in conjunction with more attention devoted to the details of treatment, the incidence of the immediate reactions as well as their severity will be greatly reduced. A method has been

described which seems to fulfill these requirements. A device† which is essential in the administration of the slow injection method is illustrated.

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## SYPHILIS AND GONORRHEA IN MICHIGAN

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A total of 15,872 cases of syphilis and gonorrhea was reported to the Michigan Department of Health in 1937. Admittedly, this total is far from the true incidence of these venereal diseases in Michigan. An analysis, however, of the available data regarding sex, age, conjugal condition and geographical distribution of reported cases should be of value in directing our efforts to control these diseases.

Venereal disease reports to the Department in 1937 increased 23 per cent over the 1936 total. The major share of this increase occurred in the reporting of syphilis, the increase here being more than 38 per cent. Much of this increased reporting can be attributed to the widespread publicity accorded the national syphilis program in 1937. More effective rules and regulations adopted by the State Council of Health for the reporting of these diseases may also have played some part in this increase.

Of the total of 15,872 cases reported, 8,888 or approximately 56 per cent were syphilis. Gonorrhea cases totaled 6,984 or 44 per cent. National surveys have indicated that gonorrhea is twice as prevalent as syphilis. From the above figures, however, it is evident that syphilis is much better reported in Michigan than is gonorrhea. This is probably explained by the fact that in syphilis the physician more often resorts to laboratory aid in making his diagnosis. Having sent a blood specimen to a state or registered laboratory, he has put himself on record. Thus he is more likely to report the case than the case of gonorrhea in which he makes the diagnosis clinically or through a slide in his own office.

As to the actual incidence of venereal diseases, it has been shown in authoritative national surveys that four persons per 1,000 population are acquiring syphilis annually and eight per 1,000 are acquiring gonorrhea. On this basis, it is estimated that there are at least 20,000 cases of early

syphilis and 40,000 cases of acute gonorrhea occurring in Michigan each year.

In this connection the statistical section of the general conference of venereal disease workers in Washington in December, 1936, made this statement: "The high annual incidence of known cases seeking treatment, the ratio of early syphilitic patients under treatment to the exposed contacts infected, and the accumulating number of untreated or inadequately treated individuals with syphilis are the basis for the estimate that *one out of ten* adults in the United States today has or has had syphilis; many of whom will remain a potential treatment problem throughout life."

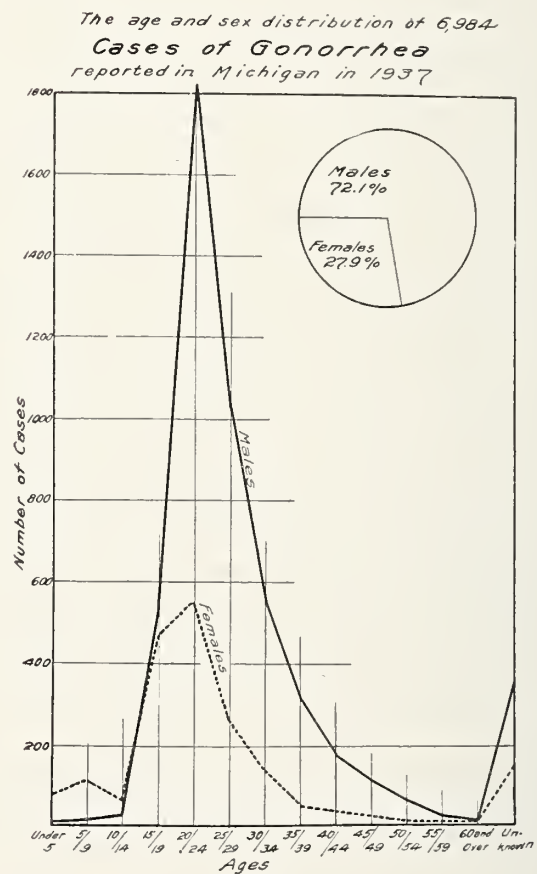
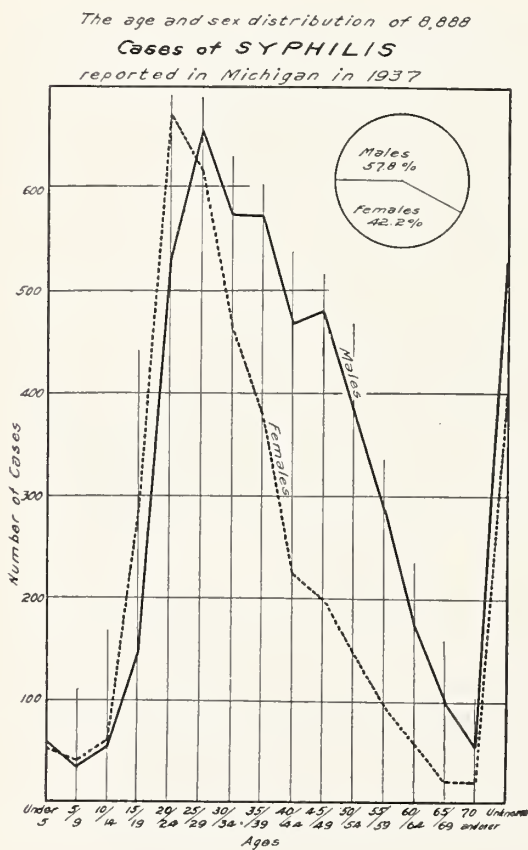
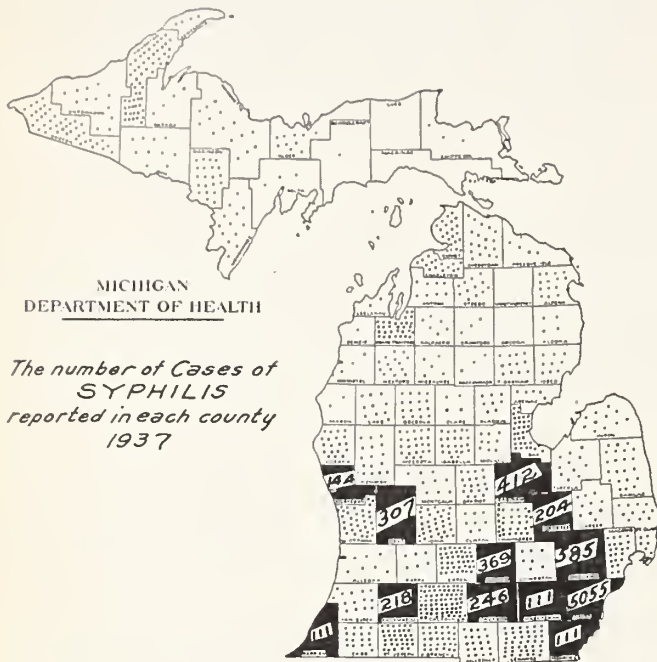
With this in view the accompanying maps showing the geographical distribution by counties of reported cases of syphilis and gonorrhea in Michigan become most pertinent. It will be observed that in four counties, Oscoda, Montmorency, Mackinac and Luce, no cases of either disease were reported. It is true that these counties are sparsely settled, yet it is still unreasonable to believe that no cases of either syphilis or gonorrhea sought medical care in these areas in 1937. Other counties, including many of the more populous ones, also show very few cases of either disease reported.

Owing to lack of exact data as to the



population of the counties and cities, no effort has been made to figure venereal disease rates. The shift of population both interstate and intrastate since the last fed-

It is an axiom of public health that no disease can be controlled without knowing when, where and under what conditions that disease is occurring. The accompanying



eral census of 1930 makes a satisfactory estimate of population impossible. Rates based on such population estimates might be very misleading. Only the total number of reported cases in each county have been shown in the present survey.

maps show how inadequately syphilis and gonorrhea are reported in many areas. The need for better reporting is evident in practically every county.

An analysis of the sex distribution of the 15,872 cases of syphilis and gonorrhea in-

# SYPHILIS AND GONORRHEA—DEACON

TABLE I. SYPHILIS IN MALES  
The Age and Conjugal Condition of Reported Cases

Ages	Single	Married	Widowed	Divorced	Unknown	Total
-5	61					61
5/9	35					35
10/14	54					54
15/19	141	8				149
20/24	398	116	3	7	8	532
25/29	344	285	4	14	9	656
30/34	216	298	11	32	19	576
35/39	181	339	13	28	15	576
40/44	168	252	18	29	4	471
45/49	126	293	28	26	11	484
50/54	67	249	41	23	6	386
55/59	38	194	39	14	3	288
60/64	21	105	40	6	2	174
65/69	10	52	29	6	4	101
70 and over	3	15	36	1	4	59
Unknown	323	144	6		58	531
Total	2186	2351	268	186	143	5133

TABLE II. SYPHILIS IN FEMALES  
The Age and Conjugal Condition of Reported Cases

Ages	Single	Married	Widowed	Divorced	Unknown	Total
-5	55					55
5/9	39					39
10/14	60				2	62
15/19	179	99		4	4	286
20/24	224	375	11	52	12	674
25/29	126	420	22	41	12	621
30/34	58	334	24	46	4	466
35/39	36	254	42	39	10	381
40/44	15	155	34	21	1	226
45/49	8	124	46	21	1	200
50/54	3	88	41	11	3	146
55/59	3	61	25	6		95
60/64	4	34	17	4	1	60
65/69	1	7	14			22
70 and over		7	13			20
Unknown	141	188	11	12	50	402
Total	952	2146	300	257	100	3755

icates that 64 per cent of the total cases occurred in males and 36 per cent in females.

As for syphilis alone, 57.8 per cent of the 8,888 cases were reported in males, a total of 5,133 cases. There were 3,755 cases of syphilis reported in females, 42.2 per cent of the total.

Of the 6,984 cases of gonorrhea, 5,034 were reported in males and 1,950 in females. The percentage distribution was 72.1 per cent in males and 27.9 per cent in females.

Table I shows the age and conjugal con-

dition of reported cases of syphilis in males. It will be observed that the greatest number of cases of syphilis, 2,351, were in married males. The single males were next with 2,186 cases. The next highest number of syphilis cases totaled 2,146 in the married females as shown by Table II. To what extent the number of syphilis cases reported among married persons is due to marital infection cannot be determined.

The age distribution of syphilis cases shows that the greatest number of cases



# SYPHILIS AND GONORRHEA—DEACON

TABLE III. GONORRHEA IN MALES  
The Age and Conjugal Condition of Reported Cases

Ages	Single	Married	Widowed	Divorced	Unknown	Total
-5	8					8
5/ 9	9					9
10/14	18					18
15/19	504	31			7	542
20/24	1459	318	2	11	34	1824
25/29	618	353	9	28	17	1025
30/34	278	245	10	12	9	554
35/39	119	160	16	10	8	313
40/44	47	96	10	18	4	175
45/49	28	68	7	9	2	114
50/54	11	33	8	5	1	58
55/59	5	14	4	1		24
60/64	1	3	2	1		7
65/69		2	1	1		4
70 and over		2	1			3
Unknown	237	96	5	6	12	356
Total	3342	1421	75	102	94	5034

TABLE IV. GONORRHEA IN FEMALES  
The Age and Conjugal Condition of Reported Cases

Ages	Single	Married	Widowed	Divorced	Unknown	Total
-5	73					73
5/ 9	112					112
10/14	56	1				57
15/19	351	102		5	7	465
20/24	246	260	6	27	12	551
25/29	59	154	10	40	2	265
30/34	16	90	9	23		138
35/39	6	29	4	10	2	51
40/44	2	28	2	8		40
45/49	1	14	5	2		22
50/54		13		1		14
55/59		4		1		5
60/64		3	1			4
65/69		1				1
70 and over						
Unknown	69	73		7	3	152
Total	991	772	37	124	26	1950

occurred in the female group age twenty to twenty-four with 674 reported cases. Only a slightly smaller number of cases, 656, occurred in the male group age twenty-five to twenty-nine. There were 621 cases of syphilis in females age twenty-five to twenty-nine and 466 cases in the thirty to thirty-four age group.

In addition to the 656 cases in males age twenty-five to twenty-nine, there were 532 cases in the twenty to twenty-four age group and 576 in both the thirty to thirty-four and thirty-five to thirty-nine age

groups. In fact, there is no great decline in prevalence until after the fifty-five to fifty-nine age group. Congenital syphilis left its mark in 190 boys and girls under the age of ten years.

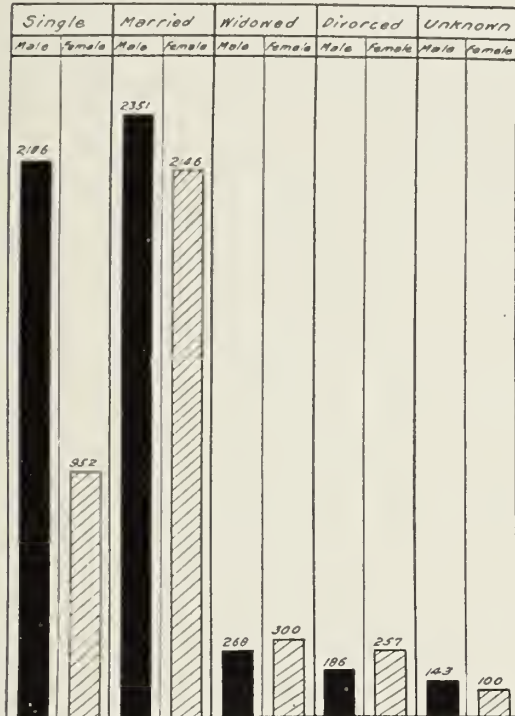
Tables III and IV indicate the age and conjugal condition of reported cases of gonorrhea in males and in females. By far the greatest number of cases, 3,342, occurred in the single males. The second highest number occurred in the married males with a total of 1,421 cases. The male age group twenty to twenty-four shows by

far the greatest incidence of gonorrhea with 1,824 reported cases. This number drops to 1,025 in the succeeding age group and then continues to decline rapidly.

rates elsewhere, it is estimated that 20,000 new cases of syphilis and 40,000 cases of acute gonorrhea occur in Michigan each year. If this is true, but 44 per cent of the

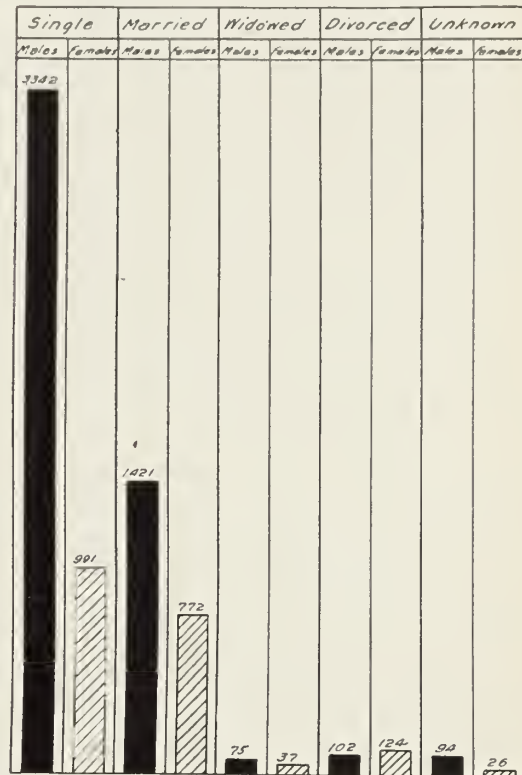
### SYPHILIS

The sex and conjugal condition of 8,888 cases reported in Michigan in 1937



### GONORRHEA

The sex and conjugal condition of 6,984 cases reported in Michigan in 1937



Gonorrhea in females is also most evident in the twenty to twenty-four age group where 551 cases were reported. The fifteen to nineteen age group shows the second greatest prevalence with 465 reported cases. The incidence falls off rapidly from 265 in the age group twenty-five to twenty-nine to 138 in the succeeding group and is thereafter negligible. The reporting of 185 cases of gonorrhea in girls under the age of ten years is significant.

### Summary

The age, sex, conjugal condition and geographic distribution of 15,872 reported cases of venereal disease have been outlined. Of this total 8,888 were syphilis and 6,984 were gonorrhea. On the basis of incidence

syphilis occurring in Michigan is being reported and but 17 per cent of the gonorrhea.

If the medical and public health professions are to cope successfully with the venereal disease problem, all cases must be placed under treatment as early as possible and kept under treatment until no longer infectious. A prompt and vigorous effort must be made to follow up all reported sources of infection and, if necessary, enforce treatment. Education of physician and public, of course, is prerequisite to adequate control of these diseases. But knowledge of the problem is fundamental and that knowledge will be complete only when case reports give a more accurate picture of when, where and under what conditions syphilis and gonorrhea prevail in Michigan.



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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 or  
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AUGUST, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### SOCIAL PROBLEMS NOT EASILY SOLVED

THE SOLUTION of the problem of medical care for the low income worker is not such an easy matter even for the social worker as we have been lead to believe in the past. The National Conference of Social Workers which met early in July at Seattle according to a news item was at a loss for a solution of the problem. The medical profession have done a little better than this. The profession is at least attempting a solution and not standing by with doctrinaire schemes. The old contention was voiced regarding those of abundant means and the very poor who received adequate care. The chief concern was for those ranging between these two extremes.

The demand is for lower medical fees for those whose incomes range from \$1,500 to \$3,000 a year. Why not go even farther and demand lower living costs for this large group of citizens? Many of their ailments are due to lack of proper food, housing and clothes. There is again the problem of preparing food; there is all the difference in the world in the appetizing meal than can be prepared from the same ingredients that so often result in a poor, not to say repulsive meal.

However, one of the speakers at the Conference of Social Workers, a socialist, offered what he called the "contract clinic" as a possible solution. As an example, we quote the following paragraph:

"It (the 'contract clinic' in Milwaukee) consists of a group of five partner physicians and two doctors hired by them, a pharmacist, laboratory technicians and others. The contract is to give medical service, operations and specialists' care for a flat fee of \$1 a month per person, or \$3 a family regardless of size. In their two years of life, they have proven it can be done, their patients receive more and better care than they could get in any other way, while the doctors receive better incomes and work under better conditions."

As we have said, however, a great deal of illness is due to improper diet, inadequate clothing and inadequate housing and we would add a fourth, ignorance in the preparation of food. This last is a matter of training in the art of preparing appetizing meals, not so easy considering the vast numbers of persons concerned.

The medical profession has sought to meet the need of the low income group in many localities by fees which range from zero to a sum that will enable the doctor to live in decency. An approximate solution of the difficulty would result if the purveyors of other services and commodities would follow suit.

We agree with the latest conclusion of the social worker, that the problem is difficult.

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### HOSPITAL CARE AND MEDICAL CARE SHOULD BE CLEARLY DEFINED

ONCE upon a time there was an Arab who owned a camel. The Arab lived in a tent of convenient size for comfort. One cold night the camel asked of his master permission just to put his head into the tent. Permission was granted the animal, and pleased with the warmth about his head in-

sinuated other portions of his anatomy by degrees until the master was crowded out into the cold entirely and the camel occupied the Arab's tent. So runs the old fable.

We have said that the group hospitalization idea is something that the medical profession can do very little to aid or prevent. We put it this way because there is much to be said in its favor as well as against it. It is largely a matter of arrangement between certain large groups of laymen acting as a unit and certain hospitals to reduce for the layman the costs of hospitalization when required. The group hospitalization idea has proved very popular in certain sections of the United States and Canada. If it is in the interest of those most directly concerned, it will have a survival value.

The good will of the medical profession by way of endorsement has been sought by hospitals contemplating group insurance. The hesitancy on the part of the council of the Michigan State Medical Society, acting for the profession, in the matter of endorsing any hospital group insurance plan is occasioned by the question of what constitutes medical care. The feeling is unanimous that the administration of anesthetics, the practice of pathology and radiology are as much medical care as obstetrics or surgery; therefore, these specialties should not be included in hospital care. Even if the anesthetist, the pathologist and the roentgenologist were willing that their services should go into any group hospitalization plan, their attitude should not receive the endorsement of the profession. If such capitulation were sanctioned by the profession, no telling how soon the entire practice of medicine and surgery might be included in group hospital insurance. Such a condition would not constitute *socialized* medicine; it would be *institutionalized* medicine. So far, however, as the medical profession is concerned, there is little or no difference. The camel would monopolize the tent.

### CAN WE AFFORD IT?

THE *New York Herald Tribune* of June 8 carried an interesting article by Harry Scherman on the subject "How Much Does Government Cost Us?" The author will be recognized by his book on economics, "The Promises Men Live By," which has been the subject of favorable comment by those able to appreciate its value. Mr.

Scherman compares the cost of government in the United States with that of other modern states. The British, he says, are generally considered to be the most heavily taxed people in the world. We, or rather the apologists of American taxation, are wont to compare our condition with that of the Britisher to his disadvantage.

"For the year ending March 31, 1938," quoting Scherman, "national taxes collected in the United Kingdom were around £841,000,000. To this much be added £176,000,000 for local taxes, a close estimate based on the latest published figures. Counting the pound at \$4.95 and the population at 47,000,000, this comes to about \$107 per person in the United Kingdom."

Mr. Scherman finds a similar condition in the United States. That is, on the same basis, taxation here averages \$107 per person in the population. In addition to this, the writer calls attention to the amount of taxes the United States has deferred by means of loans. Great Britain's national debt has increased £343,000,000 since 1930. The federal debt of the United States has increased \$21,000,000,000 during the same period. The writer goes on to say, "This prevalent notion that Americans are better off, tax-wise, than other benighted peoples seems to have become part of a fixed national pattern of thought about this matter of government expense." Of the total taxes of \$13,700,000,000 collected the present fiscal year, only about \$1,500,000,000—only about one-ninth of it—is made up of federal and state income taxes. This means that few of us are ever conscious of eight-ninths of the taxes we pay. We are so innocent in the matter of governmental finance that we do not even know we are being frisked; and much less how." Mr. Scherman estimates that an average expense for government in the United States is \$523 per family. When protest is raised against the enormous governmental expense, the come-back is "Would you let people starve?" This question usually silences the objector. Mr. Scherman, however, goes on to say that of \$523 per family, only \$90 goes for relief or welfare, and if \$90 were deducted there would still be \$433 per family chargeable to governmental expense.

Such is a summary of Mr. Scherman's article on how much does government cost. In the face of this enormous expense which has already been incurred, one can easily



imagine the result if the costs of state or socialized medicine were added to this total. One of the most extraordinary news items of the past few weeks was the announcement of an appropriation of \$850,000,000 by the Federal Government to be distributed among the states of the Union for financing medical care; the sum each state receives is to be matched by a like amount to be raised by the state itself. With Michigan attempting to solve the difficult problem of welfare, how can it raise a huge sum to equal the Federal allotment for the extension of state medicine beyond that now practiced in the state and municipal hospitals? At this writing, the city of Detroit is struggling with the raising of over a million dollars to meet the overdue grocery advances to indigent persons. Before entering upon any scheme of spending, the wise person or the wise state, which is simply the person writ large, should first sit down and calculate what his or its present obligations are, and then act accordingly.

### MEDICAL EXAMINATION FOR A DRIVER'S LICENSE

**"D**RIVERS' licenses are issued too freely. When accidents occur on the road, the blame is usually placed upon defective motors. Spasmodic safety campaigns have been sponsored by auto clubs, and tests are made from time to time by police traffic departments to determine the efficiency of brakes and the proper focusing of headlights; but what about the man at the wheel?

"The prospective driver exchanges twenty-five cents over the counter for a little card that entitles him to operate a motor vehicle. His vision, hearing, reflexes, and coördination are not tested before the collision takes place and the damage done.

"With an increasing number of vehicles on our highways, let us place the responsibility for accidents where it rightly belongs. A perfunctory questioning of the applicant's age and years of driving experience is not enough. He should be required to pass a thorough examination at the hands of a physician at least once a year. Such an examination should be regarded as a serious matter; and very definite rules should be laid down in order that uniformity might prevail. Exophoria is not confined to headlights. Good brakes and steering wheels can only perform their functions when rightly applied."

—from the *Journal-Lancet*.

Yes, and we will go much farther. A motorist might pass a physical examination 100 per cent as suggested in the paragraphs above and still be dangerous. On the other hand, one might fail in a number of the above physical requirements and be a safe driver.

The matter of temperament must also

be taken into consideration. Many accidents are the result of unadulterated bad manners; rushing ahead of some one else; cutting in or out of lines of traffic; turning out from parked positions along the curb without giving warning; making sudden left hand turns without signalling; rushing red lights; utter disregard of the rights of others. In a word, failure to obey and respect traffic rules and ordinances which are made for the good of the motoring society as a whole as well as the pedestrians.

### THE EXPERT WITNESS

Not long ago we were shown a transcript of court testimony the purpose of which among other things was to qualify a certain medical witness as an expert. Among the questions by the attorney who called the witness, was one to the effect whether he had ever written or published anything on the subject under consideration. The answer was that one of his papers had been printed in the *JOURNAL* of the Michigan State Medical Society.

Any editor should feel flattered to think that any court would accept his judgment (if it did so accept the witness as an expert). However, we disclaim the honor. No one is entitled to pose as an expert witness by having a contribution accepted for publication in this *JOURNAL* and very few we imagine would think of offering it as a qualifying factor. Contributions are accepted on their merits. Acceptance, however, is not confined to the papers of specialists. Even the specialist's position in the medical world, it goes without saying, is independent of our choice.

### PHYSICIANS AND CULTISTS

(From Report of Judicial Council, A.M.A., 1938)

**M**ANY inquiries concerning the relations of the various cults to the regular profession have been received. The inquiries pertain particularly to the osteopath and the optometrist. Some of our members are giving lectures in osteopathic and optometric schools, and addresses before their societies. Some members are associated by a common waiting room in offices with them. Some members are, by mutual agreement, professional associates principally in the field of surgery. There are some instances of partnership in practice. All of these voluntarily associated activities are unethical. Such relations certainly do not "uphold the dignity and honor of (our) vocation" or "exalt its

(Continued on Page 744)

# President's Page

## TREATING THE HEALTH PROBLEMS OF THE COMMUNITY

As one whose presidency of a great State Medical Society is drawing to a close, I am thinking about experiences of the last twelve years in organized medicine and some of the lessons I have learned.

First, I became more and more positive that physicians are honest and sincere in their work and that the medical profession leads all other groups in their service to the people. I have come to recognize that the doctor is a great individualist, giving serious consideration to the complaints of each individual patient. I believe that in this individualism there is danger to the profession because the very nature of this work interferes with the interest of the doctor in the larger problems of community health. In spite of this, the medical profession must train itself to think in terms of health for all the people, not at any time neglecting the care of the individual.

There never was a time of which we know in history when the public was demanding so much of the medical profession as at the present time. The profession must recognize these trends and meet them squarely. If it fully meets its responsibility the public will say well done. By so doing it will have gained the protection of the public, since the interests of the profession and the public go hand in hand. The danger, then, to the profession is not in what the people will do, but in what the profession shall do.

If we are, then, to fulfill our obligations as a profession, we must have an organization with the best leadership, and that leadership is entitled to the support of each individual doctor. Then and only then will our future be satisfactorily assured.



President, Michigan State Medical Society.



# Wayne University College of Medicine

## Post-Graduate Course in Internal Medicine

AT DETROIT RECEIVING HOSPITAL

SEPTEMBER 12-17, 1938

The Medical Department of Wayne University and Receiving Hospital offers an intensive review of internal medicine during the week immediately preceding the meeting of the Michigan State Medical Society. Two hours daily will be devoted to bedside diagnosis and treatment. Ward rounds will be conducted with groups of four to six post-graduates so that each physician will have the opportunity to examine every patient. The course will also include lectures on recent advances in therapeutics. The detailed program will be as follows

Time	Nature of Program	Monday Sept. 12	Tuesday Sept. 13	Wednesday Sept. 14	Thursday Sept. 15	Friday Sept. 16	Saturday Sept. 17
9-10	Therapeutic Lecture	Therapeutic Uses of the Vitamin B Complex Dr. G. Myers	Therapeutic Uses of the Gonadotropic Hormones Dr. R. Johnson	Therapeutic Uses of the Estrogenic & Androgenic Hormones Dr. F. Jackson	Therapeutic Uses of Vitamins A & D Dr. D. Sugar	Therapeutic Uses of Cevitamic Acid Dr. J. Rieger	Therapeutic Uses of Thyroid Extract Dr. R. McKean
10-12	Bedside Diagnosis and Treatment of Groups of 4 to 6	Cardiology Dr. E. Spalding	Respiratory Dis. Dr. A. E. Price	Cardiology Dr. E. Spalding	Endocrine Dis. Dr. F. Perkin	G. I. Dis. Dr. S. Meyers	Nephritis Dr. R. Johnson
		Cardiology Dr. R. Novy	G. I. Dis. Dr. H. Kullman	Cardiology Dr. R. Novy	Nephritis Dr. R. Johnson	Endocrine Dis. Dr. R. McKean	Respiratory Dis. Dr. A. E. Price
		G. I. Dis. Dr. S. Meyers	Cardiology Dr. D. Donald	Nephritis Dr. R. Schneek	Cardiology Dr. D. Donald	Respiratory Dis. Dr. C. Lemmon	Endocrine Dis. Dr. F. Perkin
		Endocrine Dis. Dr. R. McKean	Cardiology Dr. S. Rosenzweig	Respiratory Dis. Dr. C. Lemmon	Cardiology Dr. S. Rosenzweig	Nephritis Dr. R. Schneek	G. I. Dis. Dr. H. Kullman
		Nephritis Dr. R. Schneek	Endocrine Dis. Dr. F. Perkin	G. I. Dis. Dr. S. Meyers	Respiratory Dis. Dr. A. E. Price	Cardiology Dr. E. Spalding	Cardiology Dr. S. Rosenzweig
		Respiratory Dis. Dr. C. Lemmon	Nephritis Dr. R. Johnson	Endocrine Dis. Dr. R. McKean	G. I. Dis. Dr. H. Kullman	Cardiology Dr. R. Novy	Cardiology Dr. D. Donald
12:30-2			Tumor Clinic Dr. O. Brines				
2-5	Demonstration and Seminar	Diagnosis of the Anemias Dr. Vonder-Heide	Treatment of the Anemias Dr. A. H. Price	Diagnosis and Treatment of Arthritis Dr. W. Mayer	Diagnosis and Treatment of Syphilis Dr. L. Shaffer	Treatment of Diabetes Mellitus Mrs. Diton and Dr. G. Myers	

Any licensed physician may enroll. The total enrollment will be limited to 30 with a minimum of 12. Registration fee will be \$10.00, payable upon application. If the applicant is unable to attend, the fee will be refunded. For registration, apply to

DEAN'S OFFICE  
WAYNE UNIVERSITY COLLEGE OF MEDICINE,  
DETROIT, MICHIGAN.

# The 1938 Meeting



HENRY COOK, M.D.  
Flint  
*President*



P. A. RILEY, M.D.  
Jackson  
*Speaker, House of  
Delegates*



P. R. URMSTON, M.D.  
Bay City  
*Council Chairman*

## OFFICIAL CALL

THE Michigan State Medical Society will convene in Annual Session in Detroit on September 19, 20, 21, 22, 1938. The provisions of the Constitution and By-laws and the official Program will govern the deliberations.

Henry Cook, M.D.  
President

P. R. Urmston, M.D.  
Chairman of The  
Council

Philip A. Riley, M.D.  
Speaker

Attest: L. Fernald Foster,  
M.D., Secretary



L. FERNALD FOSTER, M.D.  
Bay City  
*Secretary*



H. A. LUCE, M.D.  
Detroit  
*President-Elect*



WM. A. HYLAND, M.D.  
Grand Rapids  
*Treasurer*



## CONVENTION INFORMATION

### DIRECTORY

Headquarters.....Book-Cadillac Hotel, Detroit  
 Registration and General Assemblies.....  
 Fourth Floor, Book-Cadillac Hotel  
 Press Room .....  
 Parlor F. Fifth Floor, Book-Cadillac Hotel  
 Secretary's Office .....Book-Cadillac Hotel  
 Technical Exhibits .....  
 Fourth Floor, Book-Cadillac Hotel  
 Woman's Auxiliary Headquarters.....  
 Statler Hotel, Detroit

\* \* \*

**Register—Fourth Floor Book-Cadillac Hotel, Detroit—as soon as you arrive.**

Admission by badge only to all General Assemblies and Section Meetings. Monitors at entrance. Bring your A.M.A. or county medical society membership card to expedite registration.

Hours of Registration: Daily 8:30 a. m. to 6:00 p. m. on Monday, Tuesday, Wednesday, and to 4:00 p. m. on Thursday.

No registration fee to members of the Michigan State Medical Society.

\* \* \*

**The registration at the Detroit Convention of 1936 was 1,687 (not including the ladies).**

\* \* \*

**Guests—Members of the American Medical Association from any state, or from a province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. (Please present credentials at Registration Desk.)**

Bona-fide doctors of medicine, serving as internes, residents, or who are associate or probationary members of county medical societies, if vouched for by an M.S.M.S. Councilor or the president or secretary of the county medical society, will be registered as guests. (Please present credentials at Registration Desk.)

\* \* \*

**Physicians, not members, if listed in the American Medical Directory, may register as guests upon payment of \$5.00. (This amount will be credited to them as dues in the Michigan State Medical Society for the balance of 1938 only, provided they subsequently are accepted as members by their County Medical Society.)**

\* \* \*

**Essayists are very respectfully requested not to change time of lecture with another speaker, without the approval of the General Assembly. This request is made in order to avoid confusion and disappointment on the part of the audience.**

**Seven General Assemblies, Tuesday, Wednesday, Thursday, September 20, 21, 22 (see pages 732 to 738.)**

**Public Meetings:** The Evening Assemblies of Tuesday and Wednesday, September 20 and 21, will be open to the public.

**All Section Meetings** will be held on Wednesday morning only, September 21 (see pages 729 and 730.)

### CONFERENCE FOR INTERNES AND RESIDENTS

Monday, September 19, 1938—2:30 to 3:30 P. M.

English Room (Mezzanine), Book-Cadillac Hotel, Detroit

All internes and Residents in Michigan hospitals are cordially invited to be guests of the Michigan State Medical Society at this conference.

#### Program

1. "The Value of Medical Organization to the Physician and to the Public," (10 min.)  
 R. G. LELAND, M.D., Chicago, Ill., Director, Bureau Medical Economics, A.M.A.
2. "The Place of the Michigan State Medical Society in the Young Physician's Life," (10 min.)....  
 L. FERNALD FOSTER, M.D., Bay City, Secretary, Michigan State Medical Society.
3. "Pitfalls of the Practice of Medicine—Practical Pointers," (20 min.).....  
 J. M. ROBB, M.D., Detroit, Past-President, Michigan State Medical Society.



R. G. LELAND, M.D.

#### Round Table Discussion

This Conference will be followed immediately by the symposium on "The Business Side of Medicine." Conferees are urged to remain for this valuable session.

**Parking—Do not park on the street. Use parking lots available nearby, or inside parking facilities through hotel service.**

\* \* \*

**In Case of Emergency,** doctors will be paged from the meetings by announcement on the screen.

\* \* \*

**Telephone Service—Local and long-distance telephone will be available. Inquire at Registration Desk, fourth floor, Book-Cadillac Hotel.**

JOUR. M.S.M.S.

The Seventy-six Technical Exhibits deserve your attention. The labyrinth of exhibits is so arranged that physicians may pass each display going to and returning from the General Assemblies. Progress in technical equipment, in pharmaceutical manufacture, new books, appurtenances, etc., etc.—all displayed for your interest.

Please register at each booth.

\* \* \*

Save an Order for the M.S.M.S. Exhibitor

\* \* \*

Technical Exhibits open Tuesday, September 20, at 8:30 A. M., and on Wednesday and Thursday at the same hour. Exhibits close Tuesday and Wednesday at 6:00 P. M.; Thursday at 3:30 P. M. Intermissions to view the exhibits have been arranged during the morning and afternoon General Assemblies.

### SYMPOSIUM ON "THE BUSINESS SIDE OF MEDICINE"

Monday, September 19, 1938—3:30 to 5:00 P. M.

English Room (Mezzanine), Book-Cadillac Hotel, Detroit

Arranged for secretaries and office assistants of M.S.M.S. members. Physicians and their wives are cordially welcome.

#### Program

1. "Office Secretary's Psychology with Patients and Visitors" (10 min.).
2. "Importance of Simple and Accurate Records" (10 min.).
3. "Collection Procedures" (10 min.)

Round Table Discussion

The Preventive Medicine Committee Reunion, for present and past members of the M.S.M.S. Preventive Medicine Committee, will be held Wednesday, September 21, 1938, 12:30 to 1:30 P. M., English Room, Book-Cadillac Hotel. Dr. John E. Gordon of Boston will speak on "The Highlights of Rural Roumanian Medicine."

All members of the M.S.M.S. are cordially invited to attend this subscription luncheon.

\* \* \*

**Detroit Committee on Arrangements**—Henry R. Carstens, General Chairman; Ralph H. Pino, Vice Chairman; Reception of Guest Speakers; J. A. Kasper, Chairman; Harry F. Dibble, W. B. Cooksey, Dayton H. O'Donnell, R. J. Schneck, Gerald A. Wilson. Parking: C. L. Candler, Chairman; A. D. McAlphine, J. A. McGarvah. Golf: W. R. Clinton, Chairman; C. H. Belknap, J. Kenner Bell, A. E. Catherwood, S. P. L'Esperance, R. C. Jamieson, J. C. Kenning, L. J. Morand, Wesley G. Reid, Meshel Rice, F. Janney Smith, W. J. Wilson. General Assembly Monitors: Robt. C. Moehling, Chairman; Edgar E. Martmer, John G. Mateer, Francis B. MacMillan, Frank A. Weiser, E. C. Baumgarten.

\* \* \*

**Baseball**—The Detroit Tigers will be at home during the M.S.M.S. Convention:

September 18-19—playing Washington  
September 20-21—playing Philadelphia  
September 22 —playing Cleveland

### COUNTY SECRETARIES' CONFERENCE

English Room

Book-Cadillac Hotel

TUESDAY, SEPTEMBER 20, 1938

5:30 to 8:00 P. M.

REFRESHMENTS

DINNER

TWO INFORMATIONAL ADDRESSES

All Members of the State Society Will Be Welcome at This Conference.

**Golf**—Third Annual Tournament and Banquet will be held Sunday, September 18, at Tam O'-Shanter Country Club. Flights for experts, dubs, beginners and seniors, with prizes for all, even for Kickers.

Tee off at 1:00 P. M. Dinner at 7:00 P. M.

Tam O'-Shanter is located on Walnut Lake Road, between Orchard Lake Road and Middle Belt Road, about seven miles west of Birmingham and Bloomfield Hills.

**Press Relations Committee**—J. Duane Miller, M.D., Chairman; Fred G. Buesser, M.D., David I. Sugar, M.D.

### PROGRAM SYNOPSIS

#### SUNDAY, SEPTEMBER 18

- 1:00 P. M.** Third Annual Golf Tournament.  
Tam-O'-Shanter Country Club.
- 6:30 P. M.** Meeting of The Council, M.S.M.S.  
Founders Suite, Book-Cadillac Hotel.
- 7:00 P. M.** Golfers Banquet. Presentation of Prizes.  
Tam-O'-Shanter Country Club.

#### MONDAY, SEPTEMBER 19

- 8:00 A. M.** Delegates' Breakfast.  
English Room, Book-Cadillac Hotel.
- 9:00 A. M.** First Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.
- 3:00 P. M.** Second Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.
- 8:00 P. M.** Third Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.

#### TUESDAY, SEPTEMBER 20

- 8:30 A. M.** Registration; Exhibits Open.  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M.** First General Assembly.  
Grand Ballroom, Book-Cadillac Hotel.  
(For detailed program, see page 731)



## THE 1938 MEETING

- 12:30 P. M. Committee Organization Luncheon.**  
Chairmen of 1938-39 Committees.  
Parlor H, Book-Cadillac Hotel.
- 1:30 P. M. Second General Assembly.**  
Grand Ballroom, Book-Cadillac Hotel.  
(For detailed program, see page 732.)
- 5:30 P. M. County Secretaries Conference.**  
English Room, B-C Hotel.
- 8:00 P. M. Third General Assembly.**  
Grand Ballroom, B-C Hotel.  
**PUBLIC MEETING.** (For detailed program, see page 734.)

### WEDNESDAY, SEPTEMBER 21

- 8:30 A. M. Registration; Exhibits Open.**  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M. Meetings of Sections:**
- General Medicine**  
English Room, B-C Hotel (see page 730.)
  - Surgery**  
Grand Ballroom, B-C Hotel (see page 730.)
  - Gynecology and Obstetrics**  
Washington Room, B-C Hotel (see page 730.)
  - Ophthalmology**  
Founders Suite, B-C Hotel (see page 730.)
  - Otolaryngology**  
Parlors G, H, I, B-C Hotel (see page 730.)

- Pediatrics**  
Parlor '06-'07, Book-Cadillac Hotel (see page 731).
- Dermatology & Syphilology**  
Harper Hospital (see page 731).
- 12:30 P. M. Preventive Medicine Committee Reunion Luncheon.**  
English Room, B-C Hotel.
- 12:30 P. M. Maternal Health Committee's Luncheon.**  
Washington Room, B-C Hotel.
- 1:30 P. M. Fourth General Assembly.**  
Grand Ballroom, B-C Hotel.  
(For detailed information see page 734.)
- 8:00 P. M. Fifth General Assembly.**  
Grand Ballroom, B-C Hotel.  
**PUBLIC MEETING.** (For detailed information see page 735.)

### THURSDAY, SEPTEMBER 22

- 8:30 A. M. Registration; Exhibits Open.**  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M. Sixth General Assembly.**  
Grand Ballroom, B-C Hotel.  
(For detailed information, see page 735.)
- 1:30 P. M. Seventh General Assembly.**  
Grand Ballroom, B-C Hotel.  
(For detailed information, see page 736.)
- 5:00 P. M. End of Convention.**

Save an Order for the M.S.M.S. Exhibitor

## Woman's Auxiliary

### PROGRAM

#### OFFICERS, 1937-38

- Mrs. G. C. Hicks, Jackson.....President
- Mrs. P. R. Urmston, Bay City.....President-Elect
- Mrs. L. G. Christian, Lansing.....Vice President
- Mrs. J. W. Page, Jackson.....Secretary-Treasurer
- Mrs. A. V. Wenger, Grand Rapids...Past President
- Mrs. Guy L. Kiefer, East Lansing.....
- Honorary President

- Short Talk—Morris Fishbein, M.D.,  
Chicago, Advisory Council, A.A.  
M.A.
- Honor Guests—Mrs. Chas. Tomlinson,  
National President, A.A.M.A.; Mrs.  
Guy L. Kiefer, Honorary Presi-  
dent, A.M.S.M.S.; and Mrs. Morris  
Fishbein
- Speaker—Mrs. Lawrence Hess  
Subject: "Social Hygiene"

**9:45 P. M. Bridge**

### MONDAY, SEPTEMBER 19, 1938

- 3:00 to 4:30 P. M. Office Secretaries' Confer-  
ence**
- English Room, Book-Cadillac Hotel,  
Detroit
- "Symposium on the Business Side of  
Medicine." Secretaries, doctors'  
wives and other interested indi-  
viduals invited.
- Three fifteen-minute talks and  
round-table discussion.

### TUESDAY, SEPTEMBER 20, 1938

- 10:00 A. M. Registration—Statler Hotel, De-  
troit**
- 1:00 P. M. Luncheon, Pre-Convention Board  
Meeting**
- Statler Hotel, Detroit  
1937-38 Board Members and County  
Presidents
- 6:45 P. M. Banquet—Statler Hotel, Detroit**
- Presiding Officer—Mrs. G. C. Hicks  
Chairman—Mrs. A. O. Brown

### WEDNESDAY, SEPTEMBER 21

- 10:00 A. M. Business Session, Statler Hotel,  
Detroit**
- All doctors' wives of the state are  
urged to attend
- Presentation of pins, Mrs. Chas. Tom-  
linson, Omaha, Neb., National  
President, A.A.M.A.
- 1:00 P. M. Luncheon**
- Guests—Mrs. Chas. Tomlinson  
National President, A.A.M.A.  
—H. A. Luce, M.D., Detroit,  
President, M.S.M.S.  
—President-elect, M.S.M.S.  
—L. Fernald Foster, M.D., Bay  
City, Secretary, M.S.M.S.  
—H. R. Carstens, M.D., Detroit,  
President, Wayne County  
Medical Society
- Speaker—H. S. Collisi, M.D., Grand  
Rapids, Chairman, Advisory  
Committee, W.A.M.S.M.S.  
Subject: "Marriage After  
Forty"
- 4:00 P. M. Post-convention Board Meeting**
- Mrs. P. R. Urmston presiding  
1938-39 Board Members

THE 1938 MEETING



FRANK H. LAHEY, M.D.



H. O. JONES, M.D.



J. E. MOORE, M.D.



H. A. CHRISTIAN, M.D.



A. D. RUEDEMANN, M.D.

Guest  
Speakers



C. A. ALDRICH, M.D.



Detroit  
1938



F. J. TAUSSIG, M.D.

(Additional photographs on Page 733)



S. J. SEEGER, M.D.



O. V. BATSON, M.D.  
AUGUST, 1938



J. A. BARGEN, M.D.



M. FISHBEIN, M.D.



WM. D. MCNALLY, M.D.



## PROGRAM of SECTIONS

### WEDNESDAY MORNING

September 21, 1938

#### SECTION ON GENERAL MEDICINE

English Room, Mezzanine Floor,  
Book-Cadillac Hotel

Chairman: WM. L. BETTISON, M.D., Grand Rapids  
Secretary: DOUGLAS DONALD, M.D., Detroit

##### A. M.

9:30 Massive Collapse of the Lung  
DAVID I. SUGAR, M.D., Detroit

10:00 A New Interpretation of Diabetes Mellitus in Obese Middle-Aged Patients. Recovery by Reduction of Weight  
JEROME W. CONN, M.D., Ann Arbor

10:30-11:00 Election of Officers

11:00 Sulfanilamide  
GORDON MYERS, M.D., Detroit

11:30 Fever of Undetermined Origin  
DONALD S. SMITH, M.D., Pontiac

12:00 Bromide Intoxication  
RAYMOND W. WAGGONER, M.D., Ann Arbor

#### SECTION ON SURGERY

Grand Ballroom, Fourth Floor  
Book-Cadillac Hotel

Chairman: WM. R. TORGERSON, M.D., Grand Rapids  
Secretary: M. D. WERTENBERGER, M.D., Jackson

##### A. M.

9:00 to 9:30 A Combined Operation for Cancer of the Rectum  
FRED W. RANKIN, M.D., Lexington, Ky.

9:30 to 10:00 The Treatment of Burns  
STANLEY J. SEEGER, M.D., Milwaukee

10:00 to 10:30 Limitations of Transurethral Prostatectomy  
REED M. NESBIT, M.D., Ann Arbor

10:30 to 11:00 Hemorrhoidectomy Under Regional Anesthesia (illustrated by slides and colored moving pictures)  
LOUIS J. HIRSCHMAN, M.D., Detroit

11:00 to 11:30 Knee Joint Injuries Exclusive of Fracture (with lantern slides)  
KELLOGG SPEED, M.D., Chicago

11:30 to 12:00 Election of Officers

##### P. M.

12:00 to 12:30 The Problems of Severe Hyperthyroidism  
WALTER G. MADDOCK, M.D., Ann Arbor

#### SECTION ON GYNECOLOGY AND OBSTETRICS

Washington Room, Fifth Floor  
Book-Cadillac Hotel

Chairman: NORMAN R. KRETZSCHMAR, M.D., Ann Arbor  
Secretary: CLARENCE TOSHACH, M.D., Saginaw

##### A. M.

9:00 to 9:30 Radiation Therapy in Benign Pelvic Lesions

NORMAN R. KRETZSCHMAR, M.D., Ann Arbor

9:30 to 10:00 Cesarean Section in Detroit  
WARD F. SEELEY, M.D., Detroit

10:00 to 11:00 Lymph Gland Removal in Cervix Cancer; Technics and Results  
FRED TAUSSIG, M.D., St. Louis

11:00 to 11:30 Maternal Health Survey in Michigan  
ALEXANDER M. CAMPBELL, M.D., Grand Rapids

11:30 to 12:30 Prolapse of the Uterus  
JOSEPH BAER, M.D., Chicago

Election of Officers

#### SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman: DEWEY R. HEETDERKS, M.D., Grand Rapids  
Secretary: O. B. MCGILLICUDDY, M.D., Lansing

##### OPHTHALMOLOGY

Founders' Suite, Fifth Floor  
Book-Cadillac Hotel

##### A. M.

9:30 to 10:45 Ophthalmological Round Table, to be conducted by  
A. D. RUEDEMANN, M.D., Cleveland

Subject: "Endocrine Disturbances Pertaining to the Eye"

Same subject to be repeated 11:00 A. M. to 12:15 P. M. in order that all section members may hear both papers. Members of this section are invited to change to Parlor G-H-I at 10:45 A. M. to hear Doctor Batson.

##### OTOLARYNGOLOGY

Parlors G-H-I, Fifth Floor  
Book-Cadillac Hotel

##### A. M.

9:30 to 10:45 Otolaryngological Round Table, to be conducted by  
O. V. BATSON, M.D., Philadelphia

Subject: "The Surgical Anatomy of the Ear"

Same subject to be repeated 11:00 A. M. to 12:15 P. M. in order that all section members may hear both papers. Members of this section are invited to change to the Founders' Suite at 10:45 A. M. to hear Doctor Ruedemann.

##### P. M.

12:30 Luncheon for Members of the Section on Ophthalmology and Otolaryngology. Founders' Suite, Book-Cadillac Hotel.

Election of Officers

It is important that those planning to attend the luncheon notify the Secretary at once as all places will be reserved.

## THE 1938 MEETING

### SECTION ON PEDIATRICS

Parlor '06-07 (See Bulletin Board, Fourth floor) Book-Cadillac Hotel

Chairman: ALLAN L. RICHARDSON, M.D., Detroit  
Secretary: WARD L. CHADWICK, M.D., Grand Rapids

#### A. M.

9:00 to 9:30 A Ten Year Study of Nine Hundred Reactors to Tuberculin with Particular Reference to Their Experience at Puberty

JOSEPH A. JOHNSTON, M.D., Detroit

9:30 to 9:45 Four Years' Experience with Whooping Cough Immunization

WARD L. CHADWICK, M.D., Grand Rapids

9:45 to 10:00 Experiences with Over Four Hundred Whooping Cough Immunizations

EDGAR E. MARTMER, M.D., Detroit

10:00 to 10:15 Experiences in the Treatment of One Hundred Cases of Erysipelas with Sulfanilamide

FRANKLIN H. TOP, M.D., Detroit

10:15 to 11:00 The Flat Foot Problem in Childhood (with clinical cases)

FREDERICK J. FISCHER, M.D., Detroit

11:00 to 11:15 Tetany in the New Born

JOHN L. LAW, M.D., Ann Arbor

11:15 to 12:00 The Management of Critical Situations in Childhood Nephritis

C. A. ALDRICH, M.D., Winnetka, Ill.

Election of Officers

### SECTION ON

### DERMATOLOGY AND SYPHILOLOGY

Harper Hospital, Detroit

Chairman: GEO. VAN RHEE, M.D., Detroit  
Secretary: RUTH HERRICK, M.D., Grand Rapids

#### A. M.

9:00 to 10:15 Clinic at Harper Hospital, 3839 Brush Street, Detroit

10:15 to 10:45 Discussion of cases presented

10:45 to 11:00 Chairman's Address

GEORGE VAN RHEE, M.D., Detroit

11:00 to 11:20 Mouth Lesions

ARTHUR WOODBURN, M.D., Grand Rapids

11:20 to 11:40 Skin Disturbance in Nervous Patients

MILTON G. BUTLER, M.D., Saginaw

11:40 to 12:00 Treatment of Urticaria and Allied Dermatoses

CLAUDE W. BEHN, M.D., Detroit

#### P. M.

12:00 to 12:20 Discussion

12:20 to 12:30 Election of officers

## PROGRAM of GENERAL ASSEMBLIES

### TUESDAY MORNING

September 20, 1938

#### First General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

HENRY R. CARSTENS, M.D., Presiding  
L. FERNALD FOSTER, M.D., and DOUGLAS DONALD, M.D., Secretaries

#### A. M.

9:30 "The Management of Surgical Conditions of the Common Bile Duct"

FRANK H. LAHEY, M.D., Boston, Mass.

*Harvard Medical College, 1904; Professor of Surgery, Tufts Medical School, 1913-17; Director of Surgery, A.E.F. Evacuation Hospital No. 30; Major, Medical Corps, World War; Professor of Clinical Surgery, Harvard Medical School, 1923-24. At present, Director of Lahey Clinic, Boston; Surgeon-in-Chief, New England Deaconess Hospital; Surgeon-in-Chief, New England Baptist Hospital; President, American Association for the Study of Goiter; member, American Surgical Society, International Surgical Society.*

In three thousand operations for gallstones, the following deductions have been made. The mortality of gallstones is largely related to prolonged infection and stones within the bile ducts. These

are the result of late operations for gallstones. The fatality factors in operations for gallstones exclusive of acute cholecystitis, are jaundice, hemorrhage, liver infection and diminished liver function.

Operations for gallstones, to insure the most complete relief, postoperatively, should consist in removal of the gall bladder and in addition, removal of all stones from the common and hepatic ducts, together with prolonged drainage of the biliary tree when infection is present. Indications for opening and investigating the common and hepatic ducts will be stated and this plan insures the least morbidity and the lowest mortality.

10:00 "Tubal Pregnancy"

HAROLD O. JONES, M.D., Chicago, Ill.

*Professor of Gynecology, Northwestern University Medical School; Senior Gynecologist and Chairman of the Department of Obstetrics and Gynecology, St. Luke's Hospital.*

A series of lantern slides are used to develop the idea of explaining the events in tubal pregnancy, based upon the progressive pathology. The fact that implantation is the same wherever it may take place is used to demonstrate the serious accidents that occur in tubal pregnancies.

A series of photomicrographs are used to outline the trophoblastic activity of the chorion, and also the lack of defense in the tissues not especially prepared for the reception of the fertilized ovum.

A third group of slides gives in detail the statistical data concerning the occurrence of the important symptoms.



## TUESDAY MORNING

### September 20, 1938

10:30 INTERMISSION TO VIEW THE EXHIBITS

11:00 "Syphilitic Primary Optic Atrophy"

JOSEPH E. MOORE, M.D., Baltimore, Md.

*M.D., Johns Hopkins, 1916; First Lieutenant and Captain, Medical Corps, A.E.F., 1917-19; successively Assistant, Instructor and Associate in Medicine, Johns Hopkins University, 1919 to present; Physician-in-Charge, Syphilitic Division, Medical Clinic, 1930 to present; Assisting Visiting Physician, Johns Hopkins Hospital; Member, American Society for Clinical Investigation, Association of American Physicians, American Clinical and Climatological Society; Special Consultant, U. S. Public Health Service; Consultant in Venereal Diseases, Maryland State Health Department.*

Syphilitic eye condition, if untreated, always results in blindness in both eyes. With routine treatment the blindness of a few patients is delayed, but with special forms of treatment, well known to doctors in this field, the patient may be totally protected from this complication of syphilis.

11:30 "Certain Cardiorenal Circulatory Correlations"

HENRY ASBURY CHRISTIAN, M.D., Boston, Mass.

*Johns Hopkins, 1900; Sc.D., Jefferson, 1928; LL.D., Randolph-Macon, 1923, and from Western Reserve, 1931; F.R.C.P. (Hon.), Canada, 1936; Instructor in Pathology, Harvard, 1902-05; in charge of medical students, Massachusetts General Hospital, 1905-07; Hersey Professor, Theory and Practice of Physics, Harvard, since 1908; Dean, Faculty of Medicine and Medical School, Harvard, 1908-12; Fellow Am. Acad., 1913; Corr. member, Wiener Gesellschaft f. innere Medizin, etc., 1925; Corr. member, Medico-Chirurgische Soc., Edinburgh, 1937; former Major, M.R.C., U. S. Army; Resident Chairman, Div. of Med. Sciences, Nat. Research Council, Washington, D. C., 1919-20; Physician-in-Chief, Peter Bent Brigham Hospital, Boston, since 1910.*

In all the forms of kidney lesions, as here described, the cardiocirculatory correlations play a dominant part in causing their symptoms and physical signs. Part of the proper treatment of Bright's disease, especially the chronic forms, must concern itself with the therapeutic management of the circulation; this may be, and often is, the part of the treatment that yields the best results. The physician ever should keep in mind three facts: (1) that the general circulation disturbs renal function; (2) that disturbed renal function, the result of intrarenal lesions, has an injurious effect on general circulation; (3) that there is a close correlation between extrarenal and intrarenal circulation, each in an important way influencing the other, the two together productive of the physical signs and symptoms which we encounter in our patients whose urine shows departures from normal in specific gravity, albumin content and appearance in the sediment of casts and cells. Very simple methods of history taking, physical examination and urine study, all of which can be carried out by any well trained physician in his office, suffice for an adequate understanding of the clinical problems and for a proper therapeutic management of patients with chronic Bright's disease.

12:00 "Headaches and Head Pains of Ocular Origin"

A. D. RUEDEMANN, M.D., Cleveland, Ohio

P. M.

12:30 End of First General Assembly Luncheon—

VIEW THE EXTRAORDINARY EXHIBIT

## TUESDAY AFTERNOON

### September 20, 1938

### Second General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

VERNOR M. MOORE, M.D., Presiding  
L. FERNALD FOSTER, M.D., and MORRIS D. WERTENBERGER, M.D., Secretaries

P. M.

1:30 "Babies Are Human Beings"

C. A. ALDRICH, M.D., Winnetka, Ill.

*Associate Professor of Pediatrics, Northwestern University Medical School; Associate Physician and Chairman, Pediatric Department, Evanston Hospital; Associate Attending Physician, Children's Memorial Hospital.*

The more we study human growth and development, the more we realize that babies are something very different from our traditional idea of them, and that somewhere along the line, we have failed to appreciate the peculiar value of their fundamental human qualities. It is only when we look at them against a developmental background that we begin to see them in proper perspective; as products of their evolutionary past, as dynamic living creatures and as potential adults.

In this presentation, an attempt will be made to interpret the behavior of newly born babies in the light of their purposeful nature, and to consider some of the individual differences at this age. Time will permit only the merest mention of how growth processes continually change these babies, as they grow into our complex society.

2:00 "Common Lesions of the Vulva"

FRED J. TAUSSIG, M.D., St. Louis, Mo.

*Harvard, A.B., 1893; Washington University, M.D., 1898; President, Central Association of Gynecology and Obstetrics, 1929; President, American Gynecological Society, 1937; Gynecologist, Barnard Free Skin and Cancer Hospital, 1906-1938; Professor of Clinical Obstetrics, Washington University School of Medicine.*

The vulva is a part of the skin covering the body, but also a part of the genital tract, and influenced by the ovarian hormones. Hence we have a variety of skin lesions found elsewhere such as dermatitis, furunculosis, etc., and also certain specific genital changes such as leukoplakic vulvitis. In addition, the vulva is not uncommonly infected by venereal disease. Gonorrhea produces vulvo-vaginitis in children and Bartholin abscess or cyst after puberty. Syphilis produces characteristic primary sores, mucous patches, and gummata. Of special interest are the chronic hypertrophies associated with lymphogranuloma and granuloma inguinale. In the field of neoplasms by far the most important is carcinoma, developing usually on a pre-existing leukoplakia. In spite of relative infrequency it is very important because with prompt diagnosis and proper treatment (complete vulvectomy and lymph gland removal) we can expect a five-year cure in two-thirds of the patients.

2:30 "The Treatment of Burns"

STANLEY J. SEEGER, M.D., Milwaukee, Wis.

3:00 INTERMISSION TO VIEW THE EXHIBITS

3:30 "Hearing and Deafness"

OSCAR V. BATSON, M.D., Philadelphia, Pa.

*M.D., St. Louis University, 1920. Instructor in Anatomy, University of Wisconsin, 1920-21; Assistant Professor, Associate Professor and Professor of Anatomy, University of Cincinnati, 1921-28; Professor of Anatomy, Graduate School of Medicine, University of Pennsylvania since 1928; Instructor in Otolaryngology, School of Medicine, University of Pennsylvania, since 1936; Staffs Graduate Hospital, University Hospital and Phila-*

THE 1938 MEETING



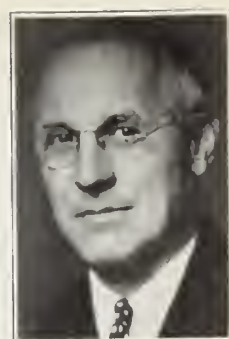
F. G. EBAUGH, M.D.



F. E. ADAIR, M.D.



J. L. BAER, M.D.



H. F. HELMHOLTZ, M.D.



R. L. HADEN, M.D.

# Guest Speakers



KELLOGG SPEED, M.D.



# Detroit 1938



KATHARINE LENROOT



R. D. MUSSEY, M.D.



R. GRINKER, M.D.



F. D. RANKIN, M.D.



H. CASPARIS, M.D.



A. F. VOSHELL, M.D.



HOWARD FOX, M.D.



## TUESDAY AFTERNOON September 20, 1938

*delphia General Hospital; Member, American Association of Anatomists, The American Academy of Ophthalmology and Otolaryngology.*

So much effort has been focused upon the obviously deafened that a slight degree of hearing deficiency might be assumed to be but a slight handicap. Many cases of small loss of hearing acuity as shown by testing methods have, for practical purposes of daily life, an almost total disability. Efforts should be made to decide upon the relative disability as well as the absolute hearing loss. The principal disabling factor in a "mixed deafness" should be determined if possible. If suited, hearing devices should be advised and the patient helped to adjust himself. The introduction of hearing aids into the schools can help pupils with a slight reduction in hearing acuity and they will help to break down the prejudice against hearing aids.

### 4:00 "The Management of the Various Types of Ulcerative Colitis"

J. ARNOLD BARGEN, M.D., Rochester, Minn.

*Associate Professor of Medicine, Mayo Foundation; Consultant in Medicine, Mayo Clinic; in charge of Intestinal Service, St. Mary's Hospital; Member, American Gastro-Enterological Association, Central Society for Clinical Research, Pan-American Medical Association, International Gastro-Enterological Association, etc.*

There are many different forms of colitis. Tuberculous colitis has been generally recognized since the turn of the century. During the second decade of this century, the pandemic, epidemic, and endemic possibilities of mebic colitis and amebiasis were discovered. During the third decade of this century, streptococic ulcerative colitis was described as an entity. Many other types of ulcerative colitis are now known. Among them, that kind in which some bodily deficiency plays a rôle should be mentioned. Also regional enteritis and many other forms of inflammatory ulcerative disease of the colon are recognized. Each of these and their management will be discussed briefly.

The term "colitis" should be applied to an intestinal condition only when demonstrable inflammation is at hand. Hence, the term "mucous colitis" is no longer tenable.

### 4:30 End of Second General Assembly

THE EXHIBITS WILL REMAIN OPEN UNTIL  
6:00 P. M.

## TUESDAY EVENING September 20, 1938

### Third General Assembly

#### Public Meeting

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

HENRY A. LUCE, M.D., Presiding  
L. FERNALD FOSTER, M.D., and C. S. TOSHACH, M.D., Secretaries

### POSTGRADUATE CONVOCATION

#### P. M.

- 8:00 1. Music by Wayne County Medical Society Glee Club
2. Call to Order
3. (a) "The Challenge of Medical Service"

JAMES D. BRUCE, M.D., Ann Arbor, Mich.

*Vice President in Charge of University Relations, University of Michigan; Chairman, Committee on Postgraduate Medical Education, Michigan State Medical Society.*

### (b) Presentation of Certificates of Associate Fellowship in Postgraduate Education, Michigan State Medical Society

### 8:30 4. "Social Aspects of Medical Care"

MORRIS FISHBEIN, M.D., Chicago, Ill.

*Rush Medical College, 1912; Editor, the Journal, A.M.A.; Hygeia; Associate Clinical Professor of Medicine, University of Chicago; Lecturer, History of Medicine, University of Illinois School of Medicine; author of many significant contributions to medical and lay literature; Member, Chicago Pathological Society, Institute of Medicine, American Association for the Advancement of Science.*

### 10:00 End of Third General Assembly

## WEDNESDAY AFTERNOON September 21, 1938

### Fourth General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

DON. W. GUDAKUNST, M.D., Presiding  
L. FERNALD FOSTER, M.D., and O. B. MCGILLICUDDY, M.D., Secretaries

### PREVENTIVE MEDICINE

#### P. M.

### 1:30 "Carbon Monoxide Poisoning"

WM. D. McNALLY, M.D., Chicago, Ill.

### 2:00 "The Obligations of the Medical Profession in Relation to Mental Health"

FRANKLIN G. EBAUGH, M.D., Denver, Colo.

*Johns Hopkins University, 1919. Director Colorado Psychopathic Hospital and Professor of Psychiatry, University of Colorado Medical School, since 1924; Director of Division of Psychiatric Education, National Committee for Mental Hygiene, since 1933; Member, American Board of Psychiatry and Neurology; Consultant at Large in Mental Hygiene in the U. S. Public Health Service.*

One of the most constructive aspects of the Mental Hygiene movement in this country has been the impetus and critical guidance it has given to medical education. By means of more intensive and thorough psychiatric teaching in the medical curriculum, the students of today are better prepared to recognize, understand and help the great number of patients who suffer from some type of personality disorder.

Mental Hygiene should enable the physician to understand himself better; it should lead to a greater enrichment of life and to a sympathetic understanding of the problems of others.

Indirectly it should enable him to care for the many baffling problems which are called "functional" which may or may not be associated with physical illness. It should also help him to understand the social or cultural pattern of the sick person in relation to his family, friends and fellow workers.

### 2:30 "The Recognition, Diagnosis, and Treatment of Breast Cancer"

FRANK E. ADAIR, M.D., New York, N. Y.

### 3:00 INTERMISSION TO VIEW THE EXHIBITS

### 3:30 "Progress in Maternal Welfare"

JOSEPH LOUIS BAER, M.D., Chicago, Ill.

*Professor of Obstetrics and Gynecology, Rush Medical College; Senior Attending Gynecologist and Attending Obstetrician, Michael Reese Hospital; Fellow, American Board of Obstetrics and*

JOUR. M.S.M.S.

## WEDNESDAY AFTERNOON September 21, 1938

*Gynecology; Institute of Medicine, Chicago; American Gynecological Society, Board of Directors, Infant Welfare Society, Chicago.*

There has long been need for better obstetric care of American women. Contrary opinion based on alleged statistical fallacies, comparisons between urban and rural data, institutional versus home deliveries, distinctions in population types, merely evades the issue. Facts about our national maternal welfare problem. Death rate in the registration area generally known. Disability rate largely ignored, a situation similar to the publicized results of auto accidents.

Prenatal care has improved. Deaths from toxemia have decreased. Deaths from sepsis and hemorrhage remain about stationary. Ignorance, poverty and lack of facilities are main factors. Improvement depends upon coöperation between the involved groups: (1) medical schools, hospitals, general practitioners and specialists; (2) the nursing profession; (3) all public agencies, community, state and federal; (4) an enlightened public.

### 4:00 "Field Studies in Scarlet Fever"

JOHN E. GORDON, M.D., Boston, Mass.

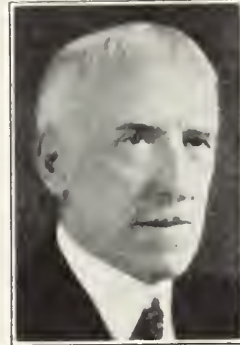
### 4:30 End of Fourth General Assembly.

SAVE AN ORDER FOR THE M.S.M.S.  
EXHIBITORS

### 8:45 9. The Andrew P. Biddle Oration: "Public Health the Product of Individual Preventive Medicine"

HAVEN EMERSON, M.D., New York, N. Y.

Presentation of Biddle Oration Scroll  
to Doctor Emerson



A. P. BIDDLE, M.D., Detroit  
Patron of Postgraduate Medical Education

### 10:00 End of Fifth General Assembly

## WEDNESDAY EVENING September 21, 1938

*Fifth General Assembly*

*Public Meeting*

Grand Ballroom, Fourth Floor, Book-Cadillac  
Hotel

HENRY COOK, M.D., Presiding  
L. FERNALD FOSTER, M.D., and WARD L. CHADWICK,  
M.D., Secretaries

### PRESIDENT'S NIGHT

P. M.

- 8:00 1. Call to order by the President
2. Invocation—Rev. Horace H. Mallinson, Detroit
3. Address of Welcome—Henry R. Carstens, M.D., Detroit, President, Wayne County Medical Society Response
4. Announcements and Reports of the House of Delegates
- 8:15 5. President's Annual Address—Henry Cook, M.D., Flint
6. Induction of Henry A. Luce, M.D., Detroit, into Office as President of the M.S.M.S.  
Presentation of Past President's Key to Henry E. Perry, M.D., Newberry, Mich.  
Responses
7. Resolutions and motions
8. Introduction of the President-Elect, and other new officers of the Michigan State Medical Society

## THURSDAY MORNING September 22, 1938

*Sixth General Assembly*

Grand Ballroom, Fourth Floor, Book-Cadillac  
Hotel

WILFRID HAUGHEY, M.D., Presiding  
L. FERNALD FOSTER, M.D., and RUTH HERRICK,  
M.D., Secretaries

A. M.

### 9:30 "The Application of Recent Advancements in Urinary Antisepsis to Private Practice"

HENRY F. HELMHOLZ, M.D., Rochester, Minn.

Diagnosis:

- A. Determination of presence of infection.
- B. Determination of type of infection  
(1) By smear; (2) By cultures.
- C. Determination of kidney function.
- D. Determination of presence or absence of urinary stasis.

Treatment:

- A. Indication for use of various urinary antiseptics according to:  
(1) Infecting organism  
(2) Renal function  
(3) Reaction of urine.
- B. Dosage of antiseptic, and mode of administration.
- C. Culture control of urine.

### 10:00 "Clinical Nutritional Deficiency Disease"

RUSSELL L. HADEN, M.D., Cleveland, Ohio

*Johns Hopkins Medical School, 1915; Director of Laboratories, Henry Ford Hospital, Detroit, 1917-18 and 1919-21; Assistant Chief of Medical Service, Base Hospital, Camp Lee, Va., 1918-19; Professor of Experimental Medicine, University of Kansas, 1923-30; Head of Division of Medicine, Cleveland Clinic, since 1930; Member, Association*



**THURSDAY MORNING****September 22, 1938**

*of American Physicians, American Society of Clinical Investigation, American Association of Pathologists and Bacteriologists, American Clinical and Climatological Association, Central Society for Clinical Research.*

The lack of specific nutritional elements often leads to definite symptoms and clinical syndromes. Definite diseases such as scurvy, beri-beri and pellegra may occur. It is much more common, however, to have typical and milder symptoms as a result of the nutritional deficiency which are usually unrecognized. Often the deficiency is multiple, making the picture more complicated.

The important nutritional elements will be reviewed, their clinical importance evaluated and the results of a deficiency described. Typical case histories will be cited. The treatment will be emphasized.

**10:30 INTERMISSION TO VIEW THE EXHIBITS****11:00 "Fractures about the Elbow Joint—to Cover All Bony Parts Entering Into the Joints"**

**"Fractures Around and In the Ankle Joint"**

KELLOGG SPEED, M.D., Chicago, Ill.

*Rush Medical College 1904. Professor of Clinical Surgery, Rush Medical College; author of a standard text-book on fractures and dislocations; attending surgeon, Presbyterian Hospital, Chicago; Fellow, American Surgical Association, American Orthopedic Association, etc.; Chairman, Fracture Committee, A.M.A.*

The anatomy of and about the knee joint is briefly reviewed to illustrate the mechanism of injuries and to recall a mental picture to the surgeon during his examination of the patient. A list of the main symptoms of the principal injuries of the knee joint, exclusive of fracture, is given and the essential points and methods of the examination are enumerated. Specimen films of conditions entering into differential diagnosis, a résumé of the author's findings in over 250 cases and the complications involving the internal structures of the joint are summarized.

**11:30 "Federal and State Co-operation in Maternal and Child Health Services"**

KATHARINE F. LENROOT, Washington, D. C.

*University of Wisconsin, 1912. Since 1914 with U. S. Children's Bureau, serving as assistant director until 1921, making studies of provision for dependent children and of methods of juvenile-court administration. In 1921 appointed Director, Editorial Division; 1922, Assistant Chief; appointed in 1934 as Chief of the Children's Bureau; Past President and now a member of the Executive Committee, National Conference of Social Work; member of the President's "Advisory Committee on Education."*

**12:00 "The Thyroid Gland and the Function of Reproduction"**

ROBERT D. MUSSEY, M.D., Rochester, Minn.

*Professor of Obstetrics, Mayo Foundation Graduate School; Head of Section on Obstetrics, Mayo Clinic; Member, American Committee on Maternal Welfare.*

Hypothyroidism may be accompanied by disturbances of menstruation, decrease in fertility and abortion. In many instances improvement is obtained by elevation of the metabolic rate by carefully regulated doses of thyroid extract. Insufficient iodine in drinking water may be accompanied by the appearance of colloid goiter at the time of menses or during puberty, pregnancy or the menopause. The high incidence of colloid goiter in certain regions makes it particularly necessary to administer iodine as a prophylactic measure. Simple or hyperfunctioning adenomas or exophthalmic goiter may complicate pregnancy. The results of management of pregnancy and of the complicating thyroid disturbance is discussed.

**P. M.**

**12:30 End of Sixth General Assembly Luncheon****A \$50,000 EXHIBIT ARRANGED FOR YOUR CONVENIENCE****THURSDAY AFTERNOON****September 22, 1938****Seventh General Assembly**

**Grand Ballroom, Fourth Floor, Book-Cadillac Hotel**

H. H. CUMMINGS, M.D., Presiding

L. FERNALD FOSTER, M.D., and E. R. WITWER, M.D., Secretaries

**P. M.**

**1:30 "Newer Methods in Neurological Diagnosis and Treatment"**

ROY R. GRINKER, M.D., Chicago, Ill.

*Rush Medical College, 1921. Formerly Associate Professor of Neurology and Associate Professor of Psychiatry, University of Chicago; at present, Chairman of Department of Neuropsychiatry, Michael Reese Hospital; author of numerous scientific publications and the text "Neurology"; Associate Editor, Tice's "Practice of Medicine" for the neuropsychiatric section.*

The most important recent advance in neurological diagnosis has come from the method of electrical recording by means of radio amplification of action potentials or so-called brain waves from the surface of the intact human skull.

Diagnosis of various types psychoses, types of epilepsies and localization of brain tumors are possible by this method.

Other diagnostic means are associated with the effects of newer chemical therapy of certain metabolic disorders. Prostigmin has an extraordinary effect on myasthenia gravis and can be used as a means of differential diagnosis. Quinine has the same value in myotonia congenita. Ergotamine tartrate acts similarly both therapeutically and diagnostically in migraine.

The greatest recent advance therapeutically is the use of shock treatment for schizophrenia, using either insulin, in sufficient doses to produce coma, or metrazol, a camphor derivative, to produce convulsions. A high percentage of schizophrenics can be brought into remissions or complete recovery. The same methods have afforded some beneficial results in other psychoses. The above advances in diagnosis and treatment will be discussed as well as other minor matters.

**2:00 "Recent Changes in the Teaching and Practice of Medicine"**

FRED W. RANKIN, M.D., Lexington, Kentucky

*M.D., University of Maryland, 1909. Assistant Surgeon, St. Mary's Hospital, Mayo Clinic, 1916-23; Professor of Surgery, University of Louisville, 1922-23; Associate Professor Surgery, University of Minnesota Medical School, Mayo Foundation; Surgeon to Mayo Clinic, 1926-33; Surgeon to St. Joseph and Good Samaritan Hospitals, Lexington, Kentucky, since 1934; author of numerous papers on operative and clinical surgery; Major, Medical Corps, U.S.A.; Commanding officer, Base Hospital No. 26; Member, American Surgical Association, American Protologic Society (Hon.); Social Clinical Surgery, etc.*

**2:30 "The Tuberculosis Program and the Practice of Medicine"**

HORTON CASPARIS, M.D., Nashville, Tenn.

*Johns Hopkins Medical School, 1919. Children's Department, Johns Hopkins, 1920-24; Professor of Pediatrics, Vanderbilt University Medical School, 1925 to present; Member, Board of Directors, National Tuberculosis Association; President, Tennessee Tuberculosis Association.*

Tuberculosis is the most serious communicable disease we have. It is preventable and controllable, and the responsibility for this rests with the general medical profession rather than with the tuberculosis specialist. The specialist is for the purpose of helping us in general practice, rather than shouldering the burden himself. If we apply the knowledge which is available concerning the control of tuberculosis, then the disease can be reduced to a minimal problem. But it is only through our constant every-day practical

JOUR. M.S.M.S.



## THURSDAY AFTERNOON

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working vigilance such as we apply to other preventable diseases, that the above can be accomplished. An attempt will be made to outline practical methods which we can all use to lessen the burden of tuberculosis and get it under control.

## 3:00 INTERMISSION TO VIEW THE EXHIBITS

## 3:30 "The Conservative Treatment of Orthopaedic Conditions"

ALLEN FISKE VOSHELL, M.D., Baltimore, Md.

*Johns Hopkins, 1919. Professor, Orthopedic Surgery, University of Maryland; Director and Surgeon-in-Chief, Kernan Hospital for Crippled Children; Chief Visiting Orthopedist, Baltimore City Hospitals, University Hospital; Visiting Orthopedist, Mercy, Woman's, Union Memorial Hospitals; author of numerous publications on Orthopedics; Lt. Commander, Medical Reserve Corps, U. S. Navy, Fellow, American Academy of Orthopedic Surgeons; Member, Robert Jones Orthopedic Club, American Orthopedic Association, American Academy of Orthopedic Surgery.*

By the above title is meant the treatment of orthopedic conditions without considering operative procedures, except as incidental associations or as preliminary to the institution of after care. In other words, the text will not describe operations nor statistics developed upon operations per se. It is desired that a realization of the value of time, development, physical and occupational therapy, vocational training and mental education be implanted in the minds of the members of the medical profession. Too much stress and importance is now being placed upon surgery and not enough upon the really more important and permanently stable aspects of orthopedic treatment. Social welfare will be discussed from the standpoint of both the patient and his family, relative to the changes incident to prolonged hospitalization, etc.

A plea for a fully rounded and balanced program of care of the crippled will be made.

## 4:00 "Treatment of Common Diseases of the Skin"

HOWARD FOX, M.D., New York

*Professor of Dermatology and Syphilology, N. Y. U. College of Medicine; Visiting Dermatologist and Syphilologist-in-charge, Bellevue Hospital; Consulting Dermatologist to numerous hospitals (15) in metropolitan area; Member, Board of Directors and Former President, American Dermatological Association; President, American Board of Dermatology and Syphilology; President American Academy of Dermatology and Syphilology; Editor-in-Chief, Archives of Dermatology and Syphilology; Honorary or Corr. Member of ten foreign dermatological societies.*

Treatment mainly from the standpoint of personal experience: Acne, value of x-rays, failure of vaccine and hormonal therapy; Rhinophyma, scarification, desiccation, excision; Rhus dermatitis, desensitization; Bromoderma, saline injections; Herpes, small pox vaccine, snake venom; Zoster, pituitrin, iodides, paraffin spray for pain; Psoriasis, anthralin, coal tar (Goeckerman method); Lupus erythematosus, gold, bismuth, quinine, local use of gold; Pemphigus, failure of germanin; Sycosis, quinolor ointment; X-ray epilation vs. fractional doses; Lupus vulgaris, salt free diet; Papulo-necrotic tuberculide, antisiphilitic treatment; Furunculosis, vaccines, toxoid; Impetigo, Alibour water, dyes; Erysipelas and chancroid, sulfanilimide; Verrucae, curette, mercury internally, x-rays, suggestion; Epithelioma, radium, desiccation, Coutard method.

## 4:30 End of Seventh General Assembly and the Convention

County Societies Secretaries' Conference will be held Tuesday, September 20, 1938, in the Book-Cadillac Hotel, Detroit, 5:30 to 8:00 P. M. Two eminent out-of-state speakers will address the secretaries. County Society presidents and delegates are invited to this important conference.

## TECHNICAL EXHIBITS

## Akron Truss Company

Space No. 75

## Detroit, Michigan

Complete showing of Surgical Appliances including Akron Trusses, Belts, Surgical Corsets, Orthopedic Braces, Limbs, Hoslery, et cetera. Mr. Ed. W. Alexander, Manager, and Mrs. C. T. Roache, Surgical Fitter, will be on duty in Booth No. 75 to explain the new improvements of Akron Appliances. Twenty-three years' service to Michigan Physicians makes this the foremost exhibit of its kind.

## A. S. Aloe Company

Space No. 4

## St. Louis, Missouri

A. S. Aloe Company, in Space No. 4, will display a general line of surgical instruments, supplies and equipment for the physician and hospital. The Aloe Short Wave Diathermy, the DeBakey Blood Transfusion Unit and many other specialties will be featured. The Michigan representative of the Aloe Company will supply those interested with brochures on Aloe Steeline, the most modern development in physician's fine treatment room furniture.

## Arlington Chemical Company

Space No. 15

## Yonkers, New York

The Arlington Chemical Company will feature their Biological and Pharmaceutical Products at the Michigan State Medical Society convention. A diagnostic protein outfit offered at \$9.75 consists of eighty of the most common factors in allergic conditions. Representatives in charge of the booth will be pleased to discuss any allergic problems.

## The Bard-Parker Company, Inc.

Space No. 7

## Danbury, Connecticut

Among the Bard-Parker products exhibited at booth No. 7 are Rib-Back Blades, Renewable Edge Scissors, stainless steel, Lahey Lock Forceps, Formaldehyde Germicide and Containers for rustproof sterilization of surgical instruments, and Hematological Case for obtaining blood samples at the bedside.

## Bilhuber-Knoll Corporation

Space No. 38

## Jersey City, New Jersey

Drugs you can use every day—Dilaudid hydrochloride for pain and cough relief; Theocalcin and Phyllicin for purine medication in heart diseases; Metrazol for stimulation in the emergency; and your old friends, Euresol and Bromural, can be discussed with well-informed representatives at this exhibit.

## Burroughs-Wellcome &amp; Company

Space No. 12

## New York, New York

The Burroughs-Wellcome & Company exhibit at Booth No. 12 presents a wide range of new and important advances in pharmacological and chemical research.

## S. H. Camp &amp; Company

Space No. 22

## Jackson, Michigan

You are cordially invited to visit Booth No. 22 where S. H. Camp & Company, manufacturers of scientific supports, will have representatives to instruct you in the latest developments of Camp Supports, show you samples and fully explain their use and application. Supports are constantly being improved to meet changing needs and these improved phases will interest you.

## Coca-Cola Company

Space No. 70

## Atlanta, Georgia

Coca-Cola will be served to the physicians with the compliments of the Coca-Cola Company.

## Cottrell-Clarke, Inc.

Space No. 64

## Detroit, Michigan

A real surprise awaits the doctor who has failed to keep in intimate touch with Michigan's own case record house, Cottrell-Clarke, Inc., Detroit. At their exhibit will be shown every form of case record, from those especially devised for the urban practitioner to their latest scientific developments for the big city specialist, clinics and hospitals.

## R. B. Davis Company

Space No. 66

## Hoboken, New Jersey

Enjoy a drink of delicious Cocomalt at Booth No. 66. Cocomalt is refreshing, nourishing and of the highest quality. It has a rich content of Vitamin D, Calcium and Phosphorus to aid the development of strong bones and sound teeth; Iron for the blood; Protein for strength and muscle; Carbohydrate for energy.



**Detroit X-Ray Sales Company** Space No. 59  
**Detroit, Michigan**

This Company again takes pleasure in presenting to the Profession the products of the F. Mattern Manufacturing Company of Chicago, and extends a cordial invitation to visit our booth and inspect a radically new design of Shockproof X-Ray Machine attractively priced. Be sure to stop at Booth No. 59.

**Dictaphone Sales Corporation** Space No. 71  
**Detroit, Michigan**

The Dictaphone Sales Corporation cordially invites you to inspect its display of Dictaphone equipment in Space No. 71, and to discuss its application in the medical profession with those in attendance. Dictaphone Dictating machines with Nuphonic recording, Transcribing machines with Nuphonic reproduction, together with S-12 Shaving machines will be on demonstration.

**Duke Laboratories, Inc.** Space No. 52  
**Long Island City, New York**

At Booth No. 52, the Duke Laboratories, Inc., will demonstrate the original, American-made, stretchable, adhesive-surfaced bandage, Elastoplast, approved by the American College of Surgeons. Elastoplast is used whenever compression and support are required, and is rapidly taking the place of the Unna Boot in the treatment of varicose ulcers. Samples of Medioplast, the Elastoplast speed compress used in the treatment of minor injuries may be had, also samples of Nivea and Basis Soap—the prescriber's cosmetics.

**Electray Equipment Company** Space No. 33  
**Detroit, Michigan**

We will show the Peerless Laboratories products, featuring a new model six meter ultra short wave, which is designed to produce maximum power output with low power consumption and especially the ability to heat low resistance tissue. Other Peerless products include a new sine and galvanic generator operated with vacuum tubes minus motor and rotating parts and their new x-ray equipment now manufactured in the same factory.

**General Electric X-Ray Corporation** Space No. 53  
**Chicago, Illinois**

It is the policy of the General Electric X-Ray Corporation to try, at each meeting of the Michigan State Medical Society, to have an interesting exhibit for the visiting doctor. All we ask is that he pay us a visit and meet our representatives who are very helpful in the matter of x-ray and physical therapy problems.

**Gerber Products Company** Space No. 45  
**Fremont, Michigan**

Gerber's, manufacturers of strained foods, in Booth No. 45, cordially invite you to inspect the strained foods on display. Two kinds of literature are available for examination and will be sent to you, on request. Part of this literature is for professional use only, but the booklets are available for distribution to mothers or adult patients on therapeutic diets.

**Gordon Shoe Company** Space No. 72  
**Detroit, Michigan**

Shoe Prescribers for twenty-two years in providing foot comfort to men, women and children. The Gordon Shoe Company has an established reputation for carrying out "Doctor's orders." You will enjoy a visit to their display and the opportunity to view a distinct and comprehensive exhibit of their famous Ground Gripper Footwear.

**Hack Shoe Company** Space No. 3  
**Detroit, Michigan**

The first display to greet your eye when you step off the elevator will be that of Detroit's internationally known "Home of Shoe Prescriptions."

Hack will exhibit HACK STABILIZER SHOES for men, women and children; Arch Supportive Gym Shoes for children; Tennis and Basketball shoes for men; Operating Room shoes; Hack-O-Pedic Clubfoot and Surgical Shoes.

**Hanovia Chemical & Manufacturing Company** Spaces No. 5 & 6  
**Newark, New Jersey**

A complete line of ultraviolet quartz lamps, Sollux Radiant Heat Lamps and Short Wave Therapy Units will be on display. Don't fail to see the new innovation, the Super "S" Alpine Sun Lamp. It lights automatically and has ten steps of intensity regulation.

Courteous representatives will be present to welcome you.

**J. F. Hartz Company** Space No. 54  
**Detroit, Michigan**

The J. F. Hartz Company will display the latest and most modern in equipment and apparatus at the September Convention. Especial attention will be given to the new Surgical Instruments. Physiotherapy equipment will also be a prominent feature of the display, and competent, well-informed attendants will be on hand to demonstrate.

**H. J. Heinz Company** Space No. 43  
**Pittsburgh, Pennsylvania**

In order that you may see the natural fresh color and uniform consistency of Heinz Strained Foods, our display presents, in an attractive manner, all twelve varieties. Naturally, you have some questions as to their preparation and uses. We, therefore, invite you to let our representative serve you in this respect.

We will be glad to send you a copy of the fifth edition of our Nutritional Chart, upon registration at our exhibit.

**Holland-Rantos, Inc.** Space No. 36  
**New York, New York**

Several new products in the field of contraception will be displayed at the Holland-Rantos booth. These in addition to the already well known Koromex diaphragm and Koromex Jelly. The new products are: H-R Emulsion Jelly, the new Koromex Diaphragm Introducer and the Bach Pessalator Set.

**Horlick's Malted Milk Corporation** Space No. 28  
**Racine, Wisconsin**

Nourishing, digestible, appetizing—these are three outstanding qualities for which Horlick's is famous, either the powdered or tablet form. Visit Booth No. 28. You will be interested in the many uses—from infant feeding to old age—note especially the convenience of the tablets, for interval feeding in ulcer diets.

**The G. A. Ingram Company** Spaces No. 62 & 63  
**Detroit, Michigan**

The G. A. Ingram Company will exhibit the new Electrocardiograph designed by Charles Hindle and manufactured by the Beck-Lee Corporation. In addition, their exhibit will include the latest physio-therapy equipment, examining room furniture, surgical instruments, and many other specialties that will be of interest to the profession. They will consider it an honor if you will stop and look over their exhibit.

**Jones Metabolism Equipment Company** Space No. 8  
**Chicago, Illinois**

The Jones Metabolism Equipment Company will feature as their display the Jones Motor Basal metabolism apparatus. A special feature of this unit is that it contains no water and requires no calculation in the determination of the basal metabolic rate.

**Jones Surgical Supply Company** Space No. 56  
**Cleveland, Ohio**

The Jones Surgical Supply Company will exhibit a complete line of surgical instruments, and sundries, short wave diathermy, suction and pressure units, along with numerous specialty items.

**A. Kuhlman & Company** Space No. 69  
**Detroit, Michigan**

A. Kuhlman and Company will show a line of Allison professional furniture, a new high power, low price suction and ether pump, an improved short wave generator, Miller Abbott tube for intestinal intubation, a line of latex urethral and retaining catheters, a new portable air purifying and odor destroying generator.

**Lea & Febiger** Space No. 55  
**Philadelphia, Pennsylvania**

Lea & Febiger will exhibit the following new works—Pohle's "Theoretical Principles of Roentgen Therapy and Clinical Roentgen Therapy"; Brenner's "Pediatric Surgery"; Perkins' "Cause and Prevention of Disease"; Steel's "Biological and Clinical Chemistry"; Weinzirl's "Hygiene"; Craig & Faust's "Clinical Parasitology"; Fishberg's "Heart Failure"; Davidoff & Dyke's "Normal Encephalogram"; Rowe's "Clinical Allergy"; Saxl's "Pediatric Dietetics," and others.

**Lederle Laboratories, Inc.** Space No. 25  
**New York, New York**

Lederle Laboratories, Inc., will feature a sea-



sonal display of therapeutic sera for all types of pneumococcus pneumonia, Globulin Modified Lederle Antitoxins; Oral and Parenteral Liver, Pergussis Antigen, Diphtheria Toxoid and the Vitamin Products, including Vi-Delga Emulsion (also available in capsule form), and Vitamin B Complex. Literature on all products will be available, as well as samples of the two vitamin products mentioned.

**Libby, McNeill & Libby** Space No. 68  
Chicago, Illinois

Libby, McNeill & Libby extend a cordial invitation to all physicians to visit the Libby booth and enjoy samples of Libby's fruit juices. The many advantages of Libby's Homogenized Baby Foods, which make babies' vegetables easier to digest than the finest straining or sieving, are graphically presented. You may register for samples and literature of these baby foods.

**Liebel-Flarsheim Company** Space No. 50  
Cincinnati, Ohio

Liebel-Flarsheim will exhibit the well-known L-F Short Wave Generators, as well as the famous Bovie Electro-Surgical Units. In addition, other new and useful physiotherapy apparatus will be shown. A cordial invitation is extended to visit the Liebel-Flarsheim booth No. 50 and have this apparatus demonstrated to you.

**J. B. Lippincott Company** Space No. 9  
Philadelphia, Pennsylvania

J. B. Lippincott Company will display NEW books: Bacon—Anus, Rectum and Sigmoid Colon; Thorek—Modern Surgical Technic; Kracke—Diseases of the Blood and Atlas of Hematology; Wilson—Fractures; Wolf—Physician's Business and New Editions of old favorites: McBride—Disability Evaluation; Rehberger—Quick Reference Book of Medicine and Surgery; Thorek—Surgical Errors and Safeguards; and Means—Thyroid and Its Diseases. See also the NEW International Clinics edited by Dr. George Morris Piersol.

**M & R Dietetic Laboratories, Inc.** Space No. 47  
Columbus, Ohio

M & R Dietetic Laboratories, Inc., will display Similac and powdered SofKurd. Representatives will be glad to discuss the merits and suggested application of these products.

**Mead Johnson & Company** Spaces No. 29 & 30  
Evansville, Indiana

Mead Johnson & Company are distributing this year an unusually fine souvenir item. It is not only beautiful but extraordinary because it contains no advertising. Ask for your copy of "Parergon." The complete display of Mead Products includes two new ones.

**Medical Arts Surgical Supply Company**  
Grand Rapids, Michigan Spaces No. 26 & 27

The Medical Arts Surgical Supply Company will feature a complete line of Hamilton medical furniture which includes the very attractive Nu Classic & Hometone suites. They will also show Physiotherapy equipment by Liebel-Flarsheim, stainless steel instruments, rotary compressors, sterilizing and autoclave equipment, and other items.

**Medical Case History Bureau** Space No. 40  
New York, New York

Inexpensive Case History Method. A system that shows at a glance the case you want, how many calls you made and when, the patient's history, the developments, diagnosis and treatments, as well as the financial status of each case, is shown in Booth No. 40 by the Medical Case History Bureau. All the history forms are displayed as they are actually kept in their cabinets.

**Medical Protective Company** Space No. 39  
Wheaton, Illinois

Ask the Medical Protective Company's representative to explain how his company meets the exacting requirements of adequate liability protection, which are peculiar to the Professional Liability field.

**The Mennen Company** Space No. 48  
Newark, New Jersey

The Mennen Company will exhibit their two famous baby products, Antiseptic Oil and Antiseptic Borated Powder. Included in the exhibit will be their complete line of shaving and after-

shave products for men. Be sure to register at the Mennen exhibit to receive your kit of samples, and participate in the prize drawing for Fitted Leather Toilet Kits.

**Merck & Company, Inc.** Spaces No. 10 & 11  
Rahway, New Jersey

Vitamin C, an essential dietary constituent, will be the featured display at the Merck booth. Individuals who are on a restricted diet frequently require a supplemental quantity of vitamin C. To be positive that they obtain the necessary amount and to be assured that the benefit of accurate dosage is derived, vitamin C is best prescribed in the form of Cebione. Cebione is the only vitamin C available that is Council accepted.

For information regarding Cebione, please register at the Merck Booth, No. 10 and 11.

**The Wm. S. Merrell Company** Space No. 46  
Cincinnati, Ohio

A number of new and interesting therapeutic agents are on display at the exhibit of The Wm. S. Merrell Company at booth number 46. Representatives in attendance will courteously show and explain any Merrell preparation of interest to visitors. Soricin, Diothane Hydrochloride, Natural Salicylates, Fibrogen and many other familiar time-tried Merrell products are also being shown.

**The C. V. Mosby Company** Space No. 2  
St. Louis, Missouri

Among the many new books to be exhibited by the C. V. Mosby Company are: Jensen's "The Heart in Pregnancy"; the Fifth Edition of Porter and Carter's "Management of the Sick Infant and Child"; Pottenger's "Symptoms of Visceral Disease"; Pruitt's "Hemorrhoids"; Watson's "Hernia"; Rea's "Neuro-Ophthalmology"; the Fifth Edition of Crossen's "Operative Gynecology," and the Sixth Edition of Clendening's "Methods of Treatment." Approximately one hundred other volumes will complete the exhibit.

**Nestle's Milk Products Company** Space No. 16  
New York, New York

Nestle's Milk Products, Inc., in Space No. 16, are exhibiting an original oil painting as the main feature of their display. The painting represents a nursery scene and is the work of Stephen Csoka, who executed the canvas especially for Nestle.

**Parke, Davis & Company**  
Detroit, Michigan Spaces No. 17-18-19-20

A number of scientific accomplishments will be displayed by Parke, Davis & Company's staff of expert technical men in charge of Booths No. 17, 18, 19 and 20. Products of special interest to the medical profession will be shown, including Mapharsen (an advance in antisyphilitic therapy), glandular products (Theelin, Adrenalin and the Pituitrin group); also Meningococcus Antitoxin, and other biological products.

**Pelton & Crane Company** Spaces No. 57 & 58  
Detroit, Michigan

The Pelton and Crane Company will exhibit the new 25-Point Pelton Sterilizers featuring 3-speed or Super-Automatic Models both with the famous Pelton "Sentry" Cutoff, self-draining cast-bronze boiler, enclosed type heater, and many other exclusive features. Also on exhibit will be the new Pelton Utility Light and the Pelton Super-Sterilizer for correct pressure sterilization in the private office, as well as representative models of the complete Pelton line of surgical Cuspidors.

**Pet Milk Company** Spaces No. 41 & 42  
St. Louis, Missouri

An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in booths numbers 41 and 42. This exhibit offers an opportunity to obtain information about the production of Irradiated Pet Milk and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk Booth.

**Petrolagar Laboratories, Inc.** Space No. 67  
Chicago, Illinois

Physicians are cordially invited to visit the new convention display at Booth No. 67 where Petrolagar Laboratories, Inc., will be represented by Messrs. R. J. Corkery and L. F. Harrison. New literature, samples and information regarding Petrolagar will be available.



**Philip Morris & Co., Ltd.  
New York, New York****Space No. 21**

Philip Morris & Co. Ltd., Inc., will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches and problems on the physiological effects of smoking.

**Physicians Equipment Exchange  
Detroit, Michigan****Space No. 73**

Renewed medical equipment will be exhibited at Booth No. 73. Something entirely new in medical equipment for your close inspection. Used, but indistinguishable from new. Completely re-enamelled and re-finished with a new furniture guarantee. (Ask the doctor who has bought our renewed medical equipment). Save half your cost.

**Picker X-Ray Corporation  
Detroit, Michigan****Space No. 23**

The very latest in a moderate priced Radiographic and Fluoroscopic shock proof and ray proof tilt table, containing all the features of an X-ray and Fluoroscopic plant. Radiographic and Fluoroscopic accessories of proven merit, such as Keraphen, Basolac, etc.

**Pocahontas Fuel Company  
Detroit, Michigan****Space No. 74**

A demonstration of Heating with Coal for Health's sake by the "O.P." completely Automatic Stoker.

Dustless coal fed from bin to furnace thoroughly burned and ash completely removed to dust-proof cans with no clinker formation. This maintains circulation of air at even temperature, the two salient requirements of body comfort and health.

Doctors, discuss your heating problems with our heating engineers.

**Professional Management  
Battle Creek, Michigan****Space No. 65**

"A Complete Business Service to the Medical Profession."

Discussing office procedures, supervision of collections, and office management; showing samples of efficient office records; distributing reprints from the Michigan State Medical Journal on "The Business Side of Medicine."

**Randolph Surgical Supply Company  
Detroit, Michigan****Spaces No. 13 & 14**

A 1939 medical furniture fair will be presented to Michigan physicians by the Randolph Surgical Supply Company. Whether or not you need new equipment, this exhibit will be worth your inspection. A varied assembly of the newest Hamilton examining tables, cabinets, et cetera, embodying advanced features of efficiency and design will be shown. Diagnostic instruments, surgical supplies, short wave and electrical equipment will be included in the display.

**Sandoz Chemical Works, Inc.  
New York, New York****Space No. 24**

"Gynergen" (Ergotamine Tartrate) for the dramatic relief of migraine; "Calglucon" (Calcium gluconate) in granules, effervescent and chocolate flavored tablets; "Neo-Calglucon," for parenteral administration; "Scillaren" and "Scillaren-B," the cardioactive principles of squill; "Digilamid," crystallized initial glucosides of digitalis lanta; the neurovegetative sedatives, Belladonal, Bellergeral and Calcibronat; Basergin and Neo-Gynergen for obstetrical use.

**W. B. Saunders Company  
Philadelphia, Pennsylvania****Space No. 49**

W. B. Saunders Company will exhibit a complete line of their books for the medical, dental, nursing and allied professions. Included in the many new books and new editions will be a brand new edition of Beckman's "Treatment," Herman's new "Urology," Buie's "Practical Proctology," Max Cutler's new Cancer book, Barsky's new "Plastic Surgery," as well as many other editions.

**Smith, Kline & French Laboratories  
Philadelphia, Pennsylvania****No. 34 & 35**

Smith, Kline & French Laboratories will distribute samples of "Benzedrine Inhaler," their Volatile vasoconstrictor. Another form of ban-

zyl methyl carbinamine S.K.F. will also be shown—"Benzedrine Solution"; as well as Pent-nucleotide, for agranulocytosis.

**E. R. Squibb & Sons  
New York, New York****Space No. 44**

Physicians attending the Michigan State Medical Society Convention are cordially invited to visit the Squibb exhibit. The complete line of Squibb Glandular, Vitamin, Arsenical and Biological Products and Specialties, as well as a number of interesting new items will be featured.

Well informed Squibb representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

**Frederick Stearns & Company****Detroit, Michigan****Spaces No. 60 & 61**

Doctors are invited to visit our booth where various outstanding contributions to medical science will be exhibited in a beautiful new modern display.

Information on such outstanding products as Neo-Synephrin Sterile Solution for parenteral use in acute hypotension; Appella Apple Powder for infantile diarrheas; Trimax, Hydrated Magnesium Trisilicate; Insulin-Stearns; and other new and interesting products will be supplied by Stearns' capable representatives.

**Van Hoosen Farms****Space No. 37****Rochester, Michigan**

Our display will emphasize three points: (a) The cleanliness and nutritive value of certified milk. (b) The production and importance of Metabolized Vitamin D Milk. (c) The high Vitamin A content of Holstein milk.

**James Vernor Company****Space No. 1****Detroit, Michigan**

Vernor's Ginger Ale needs no introduction in medical circles. Its manifold uses are familiar to dietitian and surgeon alike. The dry ice dispenser shown at Booth No. 1 at the M.S.M.S. Annual Convention and Exhibition with an appropriate display of Vernor's products, is the latest development for party uses. This unit is designed to serve a cold, tangy glass of Vernor's with all the efficiency of a fountain. Our hostess will be pleased to arrange for this service with a neat booth or stand, as you may desire.

**Wall Chemicals, Inc.****Space No. 31****Detroit, Michigan**

A display of all types of medical gas cylinders and equipment and their different uses in conjunction with gas-ether anesthesia machines and oxygen tents, et cetera. Complete disassembled valves will also be on exhibit, in order that the medical gas users will be able to gain a better conception of their structure.

**John Wyeth & Brother, Inc.  
Philadelphia, Pennsylvania****Space No. 32**

Booth No. 32, John Wyeth & Brother, Philadelphia, will feature Silver Picrate in the treatment of Trichomonas Vaginalis Vaginitis. The use of Silver Picrate in the treatment of Trichomonas Vaginitis is extremely simple, consisting of two insufflations of the Powder and supplemental use of Silver Picrate Suppositories. Silver Picrate, Wyeth, is also available in crystalline form for the preparation of fresh solution. Physicians are cordially invited to stop at the Wyeth Booth and receive full information concerning Silver Picrate and its use in Trichomonas Vaginalis Vaginitis.

**The Zemmer Company  
Pittsburgh, Pennsylvania****Space No. 51**

The Zemmer Company, Pittsburgh, Pennsylvania, manufacturers of a complete line of ethical pharmaceuticals, will occupy Space No. 51 at the 1938 Detroit Convention of the Michigan State Medical Society next September. A cordial invitation is extended to members of the medical profession to visit Exhibit Space No. 51.

**The Zimmer Manufacturing Company  
Warsaw, Indiana****Space No. 76**

The Zimmer Manufacturing Company will exhibit a complete line of fracture appliances. Among some of the new items of special interest are Smith-Petersen Nail accessories, Goniometers, Orthopedic Wrenches, Wangenstein Aspirators, New Types of Orthopedic Braces, et cetera. Mr. C. A. Fisher will be in charge of the booth.



## ANNUAL REPORT OF MEMBERSHIP COMMITTEE, 1937-38

Inasmuch as the Council of the Michigan State Medical Society approved of the activities and ideas of the Membership Committee, as presented in its report of last January, it was deemed unnecessary by its chairman to gather its individual members personally in meeting. Contact has been carried on with them through correspondence at various and odd times.

A study and analysis has been made of the various reports which have been made available to us, such as the Councilor Reports, the various statistics from Wayne County, as well as other individual County Societies' reports, and the figures as presented through the Placement Service Survey of the State Society.

From the reports of the individual councilors in January, it was found that there was a difference between the number in the societies of their jurisprudence, and the number of eligible candidates in those same counties, of one hundred and sixty-eight (168). Contact was established with those individual County Societies by correspondence where the numbers were in excess of four or more potential members. A brief detailed analysis of one or more of the counties might enlighten you as to the situations found.

As one example, there was reported a total number of eleven eligible Doctors in Monroe County who were not members of organized medicine. To be more specific, there were fifty Doctors of Medicine in Monroe County, and thirty-nine of them were members of the Michigan State Medical Society. A double check of that situation was made, and revealed this picture:

One physician is out of practice.

One physician is infirm and has practically given up his practice.

One physician is past seventy and in politics.

Four physicians are ineligible.

One physician carries membership in the Ohio State Medical Society—results 100 per cent membership of eligibles.

Similar results have been shown by most all of the other County Societies contacted. In Calhoun County, for example, there is one Doctor of Medicine who cannot be reasoned into joining the Michigan State Medical Society because he derives most all of the privileges of the American Medical Association through some special arrangement with the section of Pathology of the American Medical Association.

An effort was made to obtain members through the association with special societies. Most of these societies carry in their By-laws the rule that members of the special society must be members of their local County Medical Society. Some little response was obtained. One Society allowed that they had one member in such status. He was contacted, but to no avail. It was found that the group had overlooked, however, five others who were not members, who were seemingly being protected.

Today (June 20, 1938), there are 3,785 members, paid up in our State Society, as compared with 3,715 at this time last year, and 3,362 in 1936. Thus, an increase of 352 for 1936-'37, and an increase of 160 for 1937-'38. The increase of this past year has been one which has been spread over the State generally, and not in one locality, such as Wayne County. In comparison, the figures in Wayne County are: 1936—1,622; 1937—1,603; 1938—1,668. Thus, of the 160 increase in 1937-'38, sixty-five were from Wayne County, with the other 60 per cent being from the State generally.

Even in these times of "repression," financial insecurity, war fears, stock losses, no W.P.A. funds available through the New Deal to pay dues, and even in the face of and in spite of the increased dues of two dollars this year, there has been an increase of 4.3 per cent in the total membership of the State Society.

With these facts before us, it is the opinion of this Committee that the State Society has no reason to be other than satisfied with its total membership.

For future assistance to other Membership Committees, we would make these humble suggestions:

1. That, if possible, some activity be initiated by the State Society, to make public the rules of the special societies, and a statement as to the number of members of that Society who are not members of the State Society, possibly through publicity in the JOURNAL.

2. That contact be made with the neighboring state Societies requesting coöperation on their part to refuse membership to individuals whose residence or practice are in this state.

3. That contact be made with the American Medical Association to clarify and correct any situation wherein an M.D. may become a member of one of its special sections, and thereby obtain many of the privileges that properly belong only to individuals who have become members of their State Society.

4. A reiteration of the principle as enunciated in our January report to the effect that a tendency to let more of the sociability element in the County Societies make for greater desirability in any individual, to be an active member thereof.

Your Committee recedes into the horizon of the past with the knowledge that it has consummated the task which was assigned to it. It repines that the membership totals could not have been skyrocketed to greater heights—yet, it has the satisfaction of feeling that it has attempted and has done its justifiable part, based upon intelligent interpretation of the reality, and status, of affairs.

Respectfully submitted,

MARTIN H. HOFFMANN, M.D., *Chairman*

L. J. BAILEY, M.D.

H. M. POLLARD, M.D.

A. B. SMITH, M.D.

## ANNUAL REPORT OF ADVISORY COMMITTEE TO PAROLE COMMISSION, 1937-38

This special committee was appointed as the result of a request from the Michigan Department of Corrections for technical advice and counsel in medical matters connected with the penal institutions and the Parole Board of the State.

The program suggested to this committee divided itself into four classifications:

1. Consultation service by specialists
2. Teaching facilities for groups
3. Procuring of externes and internes for the three penal institutions
4. Referring parolees to physicians for examinations.

Your committee held two meetings with members of the Department of Corrections and physicians of the penal institutions in Jackson, and one executive meeting in Detroit.

1. *Consultation Service by Specialists:* The M.S. membership was circularized to offer its assistance in this work. The names of volunteers were listed and certified to the Department of Corrections and the wardens of the prisons, and a fee schedule was adopted.



2. *Teaching Facilities for Groups:* Negotiations with the deans of the two medical schools resulted in the decision that the prisons were too far removed from Ann Arbor and Detroit to make it practicable to transport students for ward walks.

3. *Procuring of Externes and Internes:* Arrangements were recommended to the Department of Corrections whereby the prisons could obtain externes for summer work. It was felt that second-year internes might be procured if the penal institutions could be tied up with Ypsilanti Hospital, Eloise Hospital, or other mental institutions.

4. *Referring Parolees to Physicians for Examination:* Due to the fact that in some areas (such as Detroit) approximately fifty parolees must see a psychiatrist three times a year, your committee is now working on a plan to get a list of psychiatrists to give brief examinations to these individuals at a modest fee. Your committee feels that it will be successful in this endeavor in the near future.

#### Recommendations

In view of the fact that eight out of ten who come to the penal institutions have a physical handicap, and that three out of four are repeaters, which seems to be due to a continuance of the physical handicap even after parole, it is apparent that the medical profession has a very grave responsibility to assume, in order to aid society to solve a problem which seems to be definitely medical. Therefore, your committee respectfully recommends a continuation of its functions, and an enlargement of interest in and appreciation of this vital problem by every medical practitioner of the state. Since approximately eighty per cent of the penal problem appears to be associated with a medical background, your committee feels that at least one of the five commissioners of the Michigan Department of Corrections might well be a doctor of medicine; the work of the Commission would be greatly aided by one or more commissioners having technical medical knowledge.

Your committee is grateful for the courtesies and coöperation extended to it by the Michigan Department of Corrections, John W. Miner, Chairman, and particularly to Hilmer Gellein, Director of Corrections, and to Warden Joel R. Moore of the Jackson institution.

Respectfully submitted,

P. A. RILEY, M.D., *Chairman*  
R. B. ALLEN, M.D.  
L. FERNALD FOSTER, M.D.  
A. C. FURSTENBERG, M.D.  
I. W. GREENE, M.D.

#### ANNUAL REPORT OF THE LIAISON COMMITTEE WITH THE STATE BAR OF MICHIGAN, 1937-38

The chairman of your committee has had many conferences with the chairman of a similar committee from the State Bar of Michigan, and we have found no matter of sufficient importance to warrant the calling together of the two committees for a joint meeting.

Since it appeared that no policy or activity needed development during the past year, we beg to report that your committee has not had a meeting, either of its own or with the Bar Association committee, during the current year.

Respectfully submitted,

ROBERT H. DENHAM, M.D., *Chairman*  
C. W. BRAINARD, M.D.  
S. W. DONALDSON, M.D.  
A. F. JENNINGS, M.D.  
LEMOYNE SNYDER, M.D.

#### ANNUAL REPORT OF REPRESENTATIVES TO MICHIGAN HEALTH LEAGUE, 1937-38

Several meetings were held during the year and articles of incorporation were drawn up and signed by the three representatives appointed by each of the following state societies:

The Michigan State Medical Society  
The Michigan State Dental Society  
The Michigan State Pharmaceutical Association  
The Michigan State Nurses Association.

These articles of incorporation were filed with the Secretary of State on June 22, 1938, in Lansing, Michigan.

The Michigan Health League is now a full fledged organization composed of regularly appointed representatives of these professional groups in Michigan and should serve a useful purpose in coördinating our efforts to obtain beneficial health legislation for the people. Such organizations have accomplished great things in other states and should do as much or more in Michigan. Much will depend upon the manner in which such an organization is supported by the professions forming it, but we look forward with optimism to the future success of this new Michigan Health League.

Respectfully submitted,

R. G. TUCK, M.D., *Chairman*  
L. G. CHRISTIAN, M.D.  
T. K. GRUBER, M.D.

#### ANNUAL REPORT OF THE PUBLIC RELATIONS COMMITTEE, 1937-38

The Public Relations Committee herewith respectfully submits its third annual report to the House of Delegates.

During the past year, the committee continued its organizational work as the "sales department" of the Michigan State Medical Society, integrating the many fine programs and projects emanating from The Council and the committees of the State Society. All the component county medical societies of the M.S.M.S. were assigned to the eleven members of the Public Relations Committee, who contacted fifty-two of the fifty-four units during the past twelve months. Through this personal missionary work the State Society's projects, of which the following were the more important, were successfully integrated throughout the state:

1. Placement Service
2. Model constitution and by-laws
3. Journal and technical exhibit
4. Speakers Bureau
5. Information on administration of crippled and afflicted child laws
6. Violations of Medical Practice Act
7. Committee projects:
  - (a) Preventive Medicine
  - (b) Mental Hygiene
  - (c) Maternal Health
  - (d) Cancer
  - (e) Syphilis, Tuberculosis
  - (f) Radio
  - (g) Occupational Disease
  - (h) Membership
  - (i) Advisory Committee to Woman's Auxiliary
  - (j) Ethics

#### AMA Survey

The most important project referred by the Executive Committee of The Council to the Public Relations Committee (in 1938) was the A.M.A. Survey. Our committee was instructed to develop the mechanics and the publicity on this statewide study of the distribution of medical care.



In order to effectively initiate this major objective, the Committee invited Dr. R. G. Leland, Director of the Bureau of Medical Economics, American Medical Association, to outline the details of the A.M.A. Survey to the committee members; Doctor Leland accepted the invitation and visited Lansing on March 21, 1938, and the movement was vigorously inaugurated. At the present time, and during the ensuing year, the Public Relations committee is and will maintain a sustained drive to keep up the interest of all county medical societies to the end that the A.M.A.'s Survey in Michigan may be eminently successful. The Committee is grateful to the A.M.A. and to Doctor Leland for generous assistance and wise counsel in this matter.

In addition to the missionary work (personal appearances) of the Public Relations Committee members, the Committee issued bulletins to all county medical societies and periodically to the entire membership. These messages, by direction of the Executive Committee of The Council, were incorporated in the monthly Secretary's Letter.

### Recommendations

The Committee respectfully recommends:

1. During the next twelve months, each county medical society consider the A.M.A. Survey its most vital project because

(a) The American Medical Association is calling upon each county medical society to assume this obligation;

(b) This is organized medicine's opportunity to corral authentic information, by physicians making the study themselves, aided by other groups who have technical information. It will have good education value in the community. It will instill in the profession greater confidence that their county medical societies have the ability to accomplish real service to them and the public;

(c) The profession in each county must realize its civic responsibility; physicians must assume more and more influence in all matters touching the practice of medicine.

2. Continuation of missionary work by personal appearances of the Public Relations Committee members to their assigned county medical societies.

3. Continuation of the precedent that each committee's plans and projects be made the object of special integration, to the end that the medical profession presents a united front to all interests not purporting to maintain the tradition of medicine, and at all times keeping in mind the welfare of the people and that of the practitioner of medicine.

Respectfully submitted,

L. FERNALD FOSTER, M.D., *Chairman*  
F. T. ANDREWS, M.D.  
A. F. BLIESMER, M.D.  
A. E. CATHERWOOD, M.D.  
C. G. CLIPPET, M.D.  
C. D. HART, M.D.  
DEAN W. HART, M.D.  
L. E. HOLLY, M.D.  
F. B. MINER, M.D.  
H. L. MORRIS, M.D.  
A. V. WENGER, M.D.

### ANNUAL REPORT OF ADVISORY COMMITTEE ON OCCUPATIONAL DISEASES, 1937-1938

Your committee met informally at the Krogstad conference on Occupational Diseases in Detroit on October 21 and 22, 1937; also formally, at a joint meeting with the five Commissioners of Labor and Industry and the Executive Committee of The Council of the Michigan State Medical Society in

AUGUST, 1938

Lansing on November 10, 1937; also in Detroit on January 11, 1938.

The committee was able to borrow a copy of the Krogstad symposium, for the purpose of selecting those portions of greatest interest to the medical profession for insertion in The JOURNAL of the M.S.M.S.

Since the Occupational Disease Law (Act No. 61 of 1937) became effective on October 29, 1937, only twenty claims have been filed on which service has been made on the defendants. To date (July 5, 1938) no hearings have been scheduled before medical commissions and no compensation has been paid.

The Labor Commissioners requested the State Society to nominate names in the various counties to serve on the medical commissions, as per Section Six of the Occupational Disease Law. The State Society and this committee pledged its assistance to the Labor Commission, and sought nominations for these commissions from the fifty-four county medical societies; seventeen societies have certified their lists for the medical commissions.

Your committee believes that all medical work pertaining to the Occupational Disease bill should be governed and regulated through the Michigan State Medical Society. This can best be accomplished by the county medical societies designating certain qualified individuals in all localities of the State who can best aid the Department of Labor and Industry in its administration of the technical and scientific phases of this important legislation.

Your committee recommends an increased interest on the part of the practitioner of medicine in the work of the Department of Labor and Industry, with particular reference to occupational disease administration. The committee feels that with the inevitable increase of medical questions and problems which will be placed before the Department, that consideration should be given to the eventual appointment of a Doctor of Medicine as one of the five Commissioners of Labor and Industry, in the interest of the workers served.

Respectfully submitted,  
PAUL A. KLEBBA, M.D., *Chairman*  
HENRY COOK, M.D.  
LEMOYNE SNYDER, M.D.  
EARL G. KRIEG, M.D.  
C. K. VALADE, M.D.

### ANNUAL REPORT OF CANCER COMMITTEE, 1937-1938

During the past four years it has been the opinion of the Cancer Committee that its chief function was lay cancer education and that the principal way to improve the cancer situation was to stimulate enough interest, inquisitiveness and action on the part of the public so that cancer patients or potential cancer patients would go to their physicians for examination and advice. Until now, the necessity of disseminating correct cancer information among the non-medical public has appeared to be the most urgent. To this end the Committee has provided facilities for cancer talks throughout the state and has furnished cancer literature for lay distribution. In carrying out this program valuable assistance has been received from the Joint Committee on Health Education and the Committee in turn has coöperated with the Women's Field Army. We have believed that the knowledge and facilities possessed by the medical profession would be useless unless the public presented itself for their application.

The Committee now believes that in the future  
(Continued on Page 745)



## DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

### A PRELIMINARY TO SERVICE

THE old adage "Know Thyself" can be paraphrased to the physician as "Know Thy Patient."

As a preliminary to service, physicians should ascertain many facts relative to the patient and his background. This is commonly known as the history, and is commonly performed. An item, however, which is frequently overlooked by some physicians is a slight excursion into the financial background of the patient. Many patients complain, after receiving the service, of the bill; that they are startled at the size of the statement. A wise physician never surprises the patient in this manner. He has an understanding with the patient concerning the latter's ability to pay before the service is rendered. He adjusts his fee to fit the circumstances of the particular case; explains this important matter to the patient, who is deeply appreciative as a general rule, and remains a permanent patient, well satisfied and anxious to recommend the doctor to others. We recommend this understanding to all patients before the service no matter how trivial.

On the other hand, this "know thy patient" motto gives the physician an opportunity also. It allows a chance for the patient to "know thy physician." In other words, a doctor of medicine has an opportunity to bring out, in a subtle way, his cost of practicing medicine. One doctor explains to each patient, in a few sentences, the cost of "doing business," which includes, not only his education expense and office overhead, but an analysis of the actual cost of each patient who enters his office. Naturally, when a patient realizes that every time he or she enters this specialist's office it actually costs \$2.70 (in overhead and amortization charges) the patient is more appreciative of the service and more willing to pay the fee.

Much of the criticism which is being directed at the medical profession (definitely stimulated by proponents of socialized medicine) would be eliminated if every physician would make it a point to explain to

his patient the cost of practicing medicine—that approximately 50 cents out of every dollar represents the expense of doing business.

To keep the old patients, and to make new ones, discuss the patient's ability to pay before the service is rendered. Likewise, show the cost of practicing modern medicine so that the patient knows that the armamentarium of medicine—mostly education and equipment—is a prerequisite to cover care of his body.

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### LATEST ATTACK ON FREE SPEECH

FOLLOWING is the statement of the Michigan State Medical Society in answer to the announcement of Thurman Arnold, Assistant Attorney General, in connection with the investigation of the medical profession:

Because the medical profession of the country raises its voice in favor of better practice of medicine, it appears that attempts are being made to intimidate it into submissive silence.

Corporate practice of medicine is inimical to the best public interests because it tends to wipe out the fundamental essential of good medical care—the personal attention and interest by the physician to the individual patient.

If medicine were a completed science in which symptoms could be dialed into a computing machine—a crank turned—and a box of the proper pills discharged from a slot, the considerations might be different. This, however, is not the case. Medicine is only an infant science. The eccentricities, peculiarities, and individual factors in human beings make every diagnosis and treatment dependent very heavily on personal deduction, allowances for this and that, and careful reasoning by the physician.

Another objection to corporate practice of medicine: where a medical service becomes a medium of profit by a corporation, the *quality of medical service deteriorates*, and the results to the public are disastrous.

The members of the medical profession would welcome an honest investigation of the activities of organized medicine in order that the loose accusations and the implanting in the public mind of doubts as to the high morals and ethics of the medical profession may be disproved. But it must be a fair, impartial and unprejudiced investigation, one that will bring out the truth, and will insure the right of free speech and action.

#### MATERNAL HEALTH COMMITTEE LUNCHEON

The Maternal Health Committee is sponsoring a luncheon for members of the state and all county medical societies' maternal health committees, Wednesday, September 21, 1938, 12:30 to 1:30 P. M., Washington Room, Book-Cadillac Hotel, Detroit. Dr. Joseph L. Baer of Chicago will speak on "The Opportunities and Responsibilities of the Committees on Maternal Health of County Medical Societies."

All members of the M.S.M.S. are cordially invited to attend this subscription luncheon.

#### A BILLION A YEAR FOR MEDICAL CARE?

The National Health Conference, called by the Inter-departmental Committee to Coördinate Health and Welfare Activities, was held in Washington, D. C., July 18, 19, 20. The program recommended by the technical committee outlined plans of governmental medical care which would cover practically all the population of the country, including compulsory health insurance for people with incomes up to \$3,000.00. The taxpayers' expenditure for this medical care would total some \$850,000,000 per annum!

The Technical Committee's recommendations are published in full in the *Journal of the American Medical Association*, pages 432 to 454.

A study of this ambitious and costly program should be made by every physician who is now engaged in the private practice of medicine. This is particularly recommended to those physicians elected by county medical societies as delegates to the Michigan State Medical Society House of Delegates. This subject undoubtedly will be given serious consideration by the House of Delegates at its meeting in Detroit on Monday, September 19, 1938.

#### MICHIGAN'S STATE FLOWER

In 1897 a Joint Resolution was passed by the State Legislature "to designate and adopt a State flower." It read as follows:

Whereas, A refined sentiment seems to call for the adoption of a State flower; and

Whereas, Our blossoming trees add much to the beauty of our landscape, and Michigan apples have gained a world-wide reputation; and

Whereas, At least one of the most fragrant and beautiful flowered species of apple, the *pyrus coronaria*, is native to our State; therefore

Resolved by the Senate and House of Representatives of the State of Michigan, That the apple blossom be and the same hereby is designated and adopted as the State flower of the State of Michigan.

Approved April 28, 1897.

AUGUST, 1938

#### PHYSICIANS AND CULTISTS

(Continued from Page 722)

standards." In case of emergency no doctor should refuse a sufferer knowledge or skill which he possesses to the sufferer's harm but this is quite a different matter from that of a consultant or practitioner, who, by consulting or practicing with him, assists a cultist to establish himself as competent and on the same basis of medical knowledge as a doctor of medicine. By the very nature of the education and training of each, a consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree to which it elevates the honor and dignity of the irregular in training and practice. Practicing as a partner or otherwise has the same effect and objection. Teaching in cultist schools and addressing cultist societies is even more reprehensible, for such activities give public approval by the medical profession to a system of healing known to the profession to be substandard, incorrect and harmful to the people because of its deficiencies. There hardly can be a voluntary relationship between a doctor of medicine and a cultist which is ethical in character.

#### ANNUAL REPORT OF CANCER COMMITTEE, 1937-1938

(Continued from Page 743)

it should direct a large portion of its effort in the direction of the medical profession in an attempt to arouse the interest of the doctors in the state and furnish them with concise and accurate cancer information of a practical nature. The opportunities and value of such a program are limited only by the budgetary restrictions imposed upon the committee. In Michigan alone about 25,000 cases of cancer exist and between 8,000 and 10,000 new cases develop each year. This seems to be a fertile field for the medical profession. Many cases, at present, are not being properly examined, advised and treated. Many doctors are not particularly interested in cancer. Cancer should be a satisfactory disease for the doctor to deal with because at least half of all cancer cases are readily diagnosed and treated at the proper stage. The Cancer Committee can only suggest that the 4,000 members of this society increase their interest and improve their knowledge of cancer.

Cancer is still an important problem in health education and it might appear that the indirect approach is still the best. Much can be done by a stimulated public interest, allaying unreasoning fear, dispelling undue pessimism, telling the public that they must consult their physician whenever a suspicion of cancer exists and better still report to him at regular frequent intervals for complete examination to detect or rule out cancer. However, the success of the Women's Field Army has been such that in the future it will be in a position to assume much of the financial burden of lay cancer education.

OSBORNE A. BRINES, M.D., *Chairman*

F. A. COLLIER, M.D.

DON W. GUDAKUNST, M.D.

WM. A. HYLAND, M.D.

A. H. KRETCHMAR, M.D.

ALFRED LABINE, M.D.

A. B. MCGRAW, M.D.

C. C. SLEMONS, M.D.

H. J. VANDENBERG, M.D.

C. V. WELLER, M.D.



## EXECUTIVE COMMITTEE OF THE COUNCIL

June 30, 1938

## HIGHLIGHTS:

1. Agreement reached with Auditor General of Michigan and Michigan Crippled Children Commission re status of radiologists, anesthetists, and pathologists in connection with medical service rendered under the Crippled-Afflicted Children laws.
2. Spot Speakers Service established as an Activity of the M.S.M.S.
3. Certificates of "Associate Fellowship in Postgraduate Medical Education, Michigan State Medical Society," to be awarded to approximately four hundred Michigan physicians at 1938 Annual Meeting, Detroit.
4. Booklet on "Burns" to be written by M.S.M.S., at invitation of Michigan Crippled Children Commission.
5. Insurance companies to be contacted re physicians' liens in accident and health cases.
6. Detroit Committee on Arrangements for 1938 Annual Meeting, Book-Cadillac Hotel, Detroit, September 20, 21, 22, approved.
7. Annual Tour of the Upper Peninsula county medical societies by M.S.M.S. officers authorized.

1. *Roll Call.* The meeting was called to order at the summer home of Dr. H. H. Cummings in Washtenaw County, by Dr. P. R. Urmston, Chairman, at 7:40 p. m. All members were present, also Drs. Henry Cook, L. Fernald Foster, J. H. Dempster, H. A. Luce, F. A. Reeder, H. H. Cummings, M. H. Hoffmann and Executive Secretary Wm. J. Burns.

2. *Minutes.* The minutes of the meeting of May 18 were read and approved.

3. *Financial Reports.* The financial reports for the months of May and June were presented, studied, and on motion of Drs. Brunk-Moore, accepted and ordered placed on file. The Executive Secretary presented a comparison of the 1938 budget with actual expenditures for the first half of the year.

Bills payable for the month were ordered paid, motion of Drs. Brunk-Riley. Carried unanimously.

The monthly report of the Treasurer was presented. After full discussion, the Chair suggested that the Bond Committee present further report to The Council on August 3.

4. *Committee Reports.* The Executive Secretary presented a schedule of the meetings of the Council and Executive Committee, plus the 23 standing and special committees of the M.S.M.S., since the annual meeting in Grand Rapids, 1937.

(a) The Secretary reported on the meeting of the Preventive Medicine Committee and the Syphilis Control Committee on May 22 and of the T.B. Control Committee on May 20. Motion of Drs. Carstens-Brunk that the proposed changes in the Prenuptial Physical Examination Law be referred to the Legislative Committee; motion of Drs. Carstens-Brunk that the balance of the report be accepted and approved. Carried unanimously.

(b) Contact Committee to Government Agencies report was given by Drs. Cook and Foster; at the meeting of May 21 the Committee met with the Governor's Medical Survey Committee in Lansing.

At the meeting of June 1 in Lansing with the Auditor General and with a representative of the Crippled Children Commission, a final settlement of the roentgenological problem in connection with the afflicted-crippled child laws was made, so in future, radiologists, pathologists and anesthetists will be considered practitioners of medicine (and placed in Schedules A and C), and in the case of x-ray work, the fee schedule of the M.A.R. will govern. Dr. Cook felt that this new arrangement should take effect as of July 1, 1938, instead

of September 1, 1938. Motion of Drs. Carstens-Greene that the report of the Committee be accepted and that the recommendation relative to these matters taking effect as of July 1 be approved and that the coöperative work of these three groups be given commendation. Carried unanimously.

At the Contact Committee meeting of June 22, the committee contacted the Director of State Hospitals, Dr. Joseph E. Barrett; the Director of the State Dept. of Corrections, Hilmer Gellein; Dr. H. Z. Wooden of the State Dept. of Public Instruction; and Dr. Don W. Gudakunst, State Health Commissioner, re the employment of a Director for the Governor's Medical Survey. The report was accepted by the Executive Committee.

(c) Legislative Committee report was read, and approved on motion of Drs. Greene-Carstens.

The matter of negotiating with private insurance companies in an endeavor to obtain liens for physicians in accident and health cases was approved by the Executive Committee and referred to the Contract Committee on motion of Drs. Brunk-Greene. Carried unanimously.

(d) Cancer Committee report was read, and also a letter from Dr. Brines regarding possibility of financing Cancer manual; a letter from the Secretary of the Iowa State Medical Society re the Iowa Cancer manual was also presented. Motion of Drs. Carstens-Moore that the report be received. Carried unanimously.

(e) Joint Committee on Health Education report was presented by Secretary Foster.

(f) Report of the Maternal Health Committee was presented by Dr. Foster. A letter from Chairman A. M. Campbell relative to a luncheon of all maternal health committees of the state and county medical societies, on the occasion of the annual meeting, was discussed. It was felt the committee could proceed with plans for a subscription luncheon. Motion of Drs. Greene-Brunk that the report of the committee be accepted. Carried unanimously.

(g) Distribution of Medical Care Committee report was presented by Dr. Foster, who praised Dr. Tuck's report on the green questionnaires recently mailed to all M.S.M.S. members. Motion of Drs. Brunk-Moore that copies of this survey be sent to members of the Executive Committee before August 3, for study and report, and that Dr. Pino be invited to the meeting of the Council for a full discussion of this work.

(h) Postgraduate Medical Education Committee reported through Dr. H. H. Cummings. Motion of Drs. Riley-Brunk that the M.S.M.S. print the postgraduate certificates on bonded paper. Carried unanimously. The Executive Committee also instructed the Executive Secretary, at the suggestion of Dr. Cummings, to bill \$1.00 to each M.S.M.S. member who had received last year's postgraduate book, and who had not returned it or paid for it.

(i) The monthly reports for May and June of the Medico-Legal Committee were presented, in letters from Dr. Wm. J. Stapleton, Jr., Secretary of the committee.

5. *Report of Special Committee on Medico-Legal Activity.* This report was presented by Chairman Greene.

Motion of Drs. Moore-Greene that this report be accepted and referred to the Council. Carried unanimously.

6. *Report of Committee of radiologists on Attorney General's Opinion* was presented by Dr. Moore.

7. *Report on A.M.A. meeting.* This report was presented by Dr. H. A. Luce, who was thanked by the Executive Committee for his very lucid explanation of activities in San Francisco.

8. *Group Hospitalization.* The suggestion of Attorney Wm. J. Griffith, for a clarification of Section 3 of proposed recommendations was discussed. The Executive Committee felt that the matter should be held in abeyance until the return of Dr. T. R. K. Gruber to Michigan. The recent A.M.A. resolution and decision at the San Francisco meeting was reiterated.

9. *Membership for Army, Navy and U. S. Public Health Service Physicians,* in the M.S.M.S. This matter was discussed and the Executive Secretary was instructed to invite the physicians to attend the annual meeting, as guests.

10. *Spot Speakers Service.* The Secretary presented further information on the advantages of this service, as part of the M.S.M.S. activity. Motion of Drs. Carstens-Riley that the M.S.M.S. establish a Spot Speakers Service at once. Carried unanimously.

11. *Letter from the Council on Industrial Health of the A.M.A.* was read and referred to the Occupational Disease Committee, with request for a report in the very near future, motion of Drs. Carstens-Riley. Carried unanimously.

12. *Conference with Health Officers*—Report on this meeting was presented by Secretary Foster.

13. *Request of the Crippled Children Commission,* asking the M.S.M.S. to write a booklet on "Burns" was read and the request was approved on motion of Drs. Brunk-Carstens. Carried unanimously.

14. *Detroit Committees on Arrangements.* The personnel of these committees, appointed by Dr. H. R. Carstens as President of the Wayne County Medical Society, was approved.

15. *Tour of Upper Peninsula August, 1938,* by the M.S.M.S. officers, was discussed and on motion of Drs. Carstens-Brunk, the Chairman of the Council and the Secretary were authorized to prepare the itinerary of the annual tour of the Upper Peninsula county medical societies, and the Secretary and Executive Secretary were authorized to make this trip.

16. *Labor Board Case.* The Secretary presented the problem of one of the members relative to a compensation case. The Secretary was requested to obtain further information, as to whether this case had enjoyed the privilege of a hearing before the Labor Board.

17. *Adjournment.* The meeting was adjourned at 12:20 p. m. The Chair thanked Dr. and Mrs. Cummings for their hospitality on this occasion.

## SUPPLEMENTARY ROSTER

The following physicians, whose names did not appear in The Directory Number of THE JOURNAL, are members of the Michigan State Medical Society:

### Berrien County

Ames, John ..... Niles  
Brown, Rolland J. .... Benton Harbor  
Waterson, R. S. .... Niles

### Branch County

Schneider, H. A. .... Coldwater

### Jackson County

Braunsdorf, Robert L. .... Jackson

### Kalamazoo County

Behan, G. W. .... Galesburg

### Macomb County

Marks, J. B. .... Mount Clemens

### Midland County

Rice, Robert E. .... Midland

### Oakland County

Couchman, Boyd. .... Royal Oak  
Uloth, M. J. .... Ortonville

### St. Joseph County

O'Dell, John. .... Three Rivers

### Wayne County

Adams, James Robert. .... Dearborn  
Axelson, A. U. .... Detroit  
Berris, J. M. .... Detroit  
Boell, Arthur F. .... Detroit  
Brisbois, Harold J. .... Plymouth  
Brandt, Edward L. .... Detroit  
Conrad, E. R. .... Detroit  
Dwyer, F. W. .... Detroit  
Duggan, Geo. C. .... Detroit  
Ellis, Seth W. .... Detroit  
Ewing, C. H. .... Detroit  
Fowler, William. .... Detroit  
Gates, Nathaniel H. .... Detroit  
Gigante, Nicola. .... Detroit  
Glick, M. J. .... Detroit  
Gronow, A. A. .... Detroit  
Glazer, Walter S. .... Detroit  
Hamburger, A. C. .... Detroit  
Hart, T. M. .... Detroit  
Hunt, Verne G. .... Detroit  
Harris, Albert E. .... Detroit

Jarzembowski, F. B. .... Detroit  
Kates, Simon C. .... Detroit  
Kelly, Edward W. .... Detroit  
Koch, John C. .... Detroit  
Knapp, Bryan S. .... Detroit  
LaBine, Alfred C. .... Detroit  
Lilly, Vernon S. .... Detroit  
Levin, Michael M. .... Detroit  
MacDonell, Frank J. .... Detroit  
Martin, I. Herbert. .... Detroit  
McKinnon, Wm. R. .... Detroit  
Mead, Edward M. .... Detroit  
Miller, Hazen L. .... Detroit  
Mitchell, C. Leslie. .... Detroit  
Malone, Herbert. .... Detroit  
Murray, William A. .... Detroit  
Newman, Max Karl. .... Detroit  
Nosanchuk, Barney. .... Detroit  
Olmsted, Wm. R. .... Detroit  
Parr, R. W. .... Detroit  
Pinkus, Hermann K. B. .... Detroit

Rahm, Lambert P. .... Detroit  
Sage, Thomas. .... Detroit  
Saltzstein, Harry. .... Detroit  
Seeley, James B. .... Detroit  
Shipton, W. Harvey. .... Detroit  
Sperry, F. L. .... Detroit  
Stout, Lindley H. .... Detroit  
Tamblyn, E. J. .... Detroit  
VanDuzen, V. L. .... Detroit  
Wall, Joseph A. .... Detroit  
Ward, William K. .... Detroit  
Watkins, J. T. .... Detroit  
Weisberg, A. Allen. .... Detroit  
West, H. G. .... Detroit  
Winfield, James M. .... Detroit  
Witus, M. .... Detroit  
White, Theodore M. .... Detroit  
Zbudowski, A. S. .... Detroit  
Honor Member:  
Gibson, J. C. .... Detroit



# AUTUMN POSTGRADUATE COURSE FOR 1938

## Michigan State Medical Society—University of Michigan— Wayne University College of Medicine

The Department of Postgraduate Medicine of the University of Michigan Medical School, in conjunction with the Wayne University College of Medicine and the Michigan State Medical Society, announces the annual extra-mural postgraduate course for 1938-39. The course has been divided into two parts, the first to be given in October, 1938, and the second in April, 1939.

### Subjects for the course in October are:

#### Surgery

1. Venous and lymphatic disturbances of the extremities. A discussion of varicose veins and ulcers, phlebitis, and the various causes of swelling of the leg.
2. Intracranial and Intraspinial Injuries.

#### Dermatology and Syphilology

3. Dermatological clinic. Demonstration, diagnosis and treatment of dermatological cases. (Physicians having cases of dermatological lesions suitable for demonstration are urgently requested to notify the local chairman.)

#### Internal Medicine

4. Geriatrics. The care of the aged.

#### 5. Symposium on tuberculosis.

- (a) The Michigan Tuberculosis Association a coöperative agency.
- (b) The physicians and the tuberculosis problem.
- (c) The indications for surgery in tuberculous and non-tuberculous lesions.

#### Psychiatry

#### 6. Symposium on mental health.

- (a) The interest and responsibility of the State in mental disease. The possibilities of coöperative action in the care of the mentally diseased.
- (b) Mental hygiene of the adult.
- (c) The doctor and the child.

### Teaching Centers

### Local Chairmen

Ann Arbor .....	Dr. Howard H. Cummings, Ann Arbor
Battle Creek-Kalamazoo, jointly...	Dr. Wilfrid Haughey, Battle Creek Dr. F. T. Andrews, Kalamazoo
Flint .....	Dr. Frank E. Reeder, Flint
Grand Rapids .....	Dr. Vernor M. Moore, Grand Rapids
Lansing-Jackson, jointly .....	Dr. J. Earl McIntyre, Lansing Dr. Cecil Corley, Jackson
Manistee-Traverse City-Cadillac- Petoskey, jointly .....	Dr. Harlen MacMullen, Manistee Dr. Edw. F. Sladek, Traverse City Dr. John F. Gruber, Cadillac Dr. Gilbert Saltonstall, Charlevoix
Marquette .....	Dr. F. C. Bandy, Sault Ste. Marie Dr. W. A. Manthei, Lake Linden
Saginaw .....	Dr. Paul R. Urmston, Bay City Dr. Oliver W. Lohr, Saginaw

The announcement containing full information about the teaching schedule is available upon request.

DEPARTMENT OF POSTGRADUATE MEDICINE

University Hospital, Ann Arbor, Michigan

## WOMAN'S AUXILIARY

President—Mrs. G. C. Hicks, 1009 Wildwood Ave., Jackson, Michigan  
Sec.-Treas.—Mrs. J. W. Page, 119 N. Wisner St., Jackson, Michigan  
Press—Mrs. C. B. Fulkerson, 1535 Grand Ave., Kalamazoo, Michigan

### ANNUAL REPORT OF STATE PRESS CHAIRMAN

The year began with thirteen Auxiliaries to each of whom were sent a comprehensive letter in October requesting the appointment of a press or publicity chairman, and duties of same. Nine Auxiliaries appointed press chairmen; two Auxiliaries have made no reports (Oakland and Ottawa); one interested but inactive (Tuscola); one "bunched" report (perhaps one report for three months); two reported each month (Jackson and Kalamazoo); three missed but once each (Kent, Ingham and Monroe); three new Auxiliaries (Lapeer, Fremont and Washtenaw) organized this year through the special efforts of our State President and State Secretary, too recently to send reports. Thus the great majority have coöperated splendidly in a gratifying year's work.

Letters were also sent to the standing committee chairmen in October and splendid helpful messages in response came from the chairmen of Program, *Hygeia*, Public Relations, which appeared in the State Society JOURNAL.

Approximately sixty-six articles, inclusive of estimated reports at hand for the June issue, have been prepared and published in the State JOURNAL, with almost no curtailment until the May number, which needs must be cut due to use of fifteen pages for publishing names of members of the State Society. Our abiding and grateful appreciation is thus tendered Dr. Dempster, Editor, for his encouragement, commendation and whole-hearted coöperation for the Woman's Auxiliary section, which has occupied from two to five pages of THE JOURNAL. A similar tribute is due the Woman's Executive Committee, especially the President and Secretary, also the Auxiliaries and committee chairmen, for unfailing coöperation and letters of appreciation.

To Monroe County goes first honor in having been first to send in 100 per cent quota dues on January 16.

Excellent reports from the mid-winter and national Board meetings were given by the State President and Secretary.

Sedulous in working for *Hygeia* are Kent, Calhoun, Bay, Jackson and Wayne; for Cancer Prevention in April, Monroe, Kalamazoo and Kent; in Public Relations, Bay and Saginaw; while several did constructive dissemination of knowledge of venereal diseases and prevention.

Kent Auxiliary has been given one or more pages in the *County Bulletin* for monthly activities of the Auxiliary. Kalamazoo Auxiliary continues its interest in the Hard of Hearing Room of the Public Schools by paying tuition of a worthy child. Kalamazoo was also outstanding in a reciprocal meeting on Presidents' Day, May 2, at the Ladies' Library Club, oldest federated club in Michigan. Mrs. W. E. Shackleton, President, was also the district organizer of the Woman's Auxiliary. The speaker was Mrs. Richard U. Light, who, with her husband, Dr. Light, just returned from a 35,000 mile flight over South America and Africa. Moving pictures, which she had taken from Cape Town to Cairo, were shown. Twelve Auxiliary members, also members of the club, acted as hostesses or presided at the tea urns (including a past

state president and the present state press chairman) at the tea which followed.

It is traditional with Jackson to have one program yearly by members or their children, and this year's program was especially charming as presented by Miss Mary Pray of the Speech Department, University of Michigan. Miss Pray is the gifted daughter of Dr. and Mrs. Pray.

Appreciation came from the Washington State Medical Auxiliary for the splendid article by our State Senator Earl W. Munshaw on State Medicine and permission was granted for making mimeographed copies of it.

A teacher of one of the schools receiving *Hygeia* states: "It is a good remedy for quackery and goes into homes often where it is much needed."

This report must needs be written before all reports are in or our year's work quite completed, so we beg forbearance in slight discrepancies.

We've enjoyed a splendid year together and my personal gratitude is extended to our charming president and secretary and to all County Auxiliaries, press and committee chairmen who have been coöperative in our success.

Special gratitude goes to Dr. Dempster, editor of THE JOURNAL, for his unfailing courtesies and liberal space granted to us, also for his confidence and appreciation through his request for greetings from your press chairman. We bespeak all this and more of joy in service to our successor. On behalf of the Executive Council we urge a full attendance at the State meeting in Detroit in September.

(Mrs. C. B.) CORA K. FULKERSON,  
State Press Chairman.

### Kalamazoo

The ladies of the Auxiliary were guests of the Academy of Medicine at the Kalamazoo Country Club on June 21. Covers were placed for 125 at dinner.

Dr. Newett of the State Department of Health addressed the meeting on County Health Units, and Dr. Richard Light gave an interesting talk on his airplane flight over South America and Africa illustrated by stereopticon views.

MRS. (HUGO) BARBARA K. AACH,  
Publicity Chairman.

Doctors' wives are invited to the Symposium on the "Business Side of Medicine," Monday, September 19, 1938—3:30 to 5:00 p. m., English Room, Book-Cadillac Hotel, Detroit.

### Program

1. "Office Secretary's Psychology with Patients and Visitors" (10 min.)—Henry C. Black, Battle Creek, Michigan.
2. "Importance of Simple and Accurate Records" (10 min.)—Miriam Zion, New York, N. Y.
3. "Collection Procedures" (10 min.)—Frank E. Parker, Detroit, Michigan.

### Round Table Discussion





# REGULATION

Regulation of the daily program, especially diet and exercise, is beneficial to normal bowel movement and in some cases of constipation serves as sufficient treatment. Others require additional aid to facilitate regular evacuation . . . When an adjunct to diet and exercise is required, as it often is, Petrolagar provides a mild but effective treatment. Its miscible properties make it easier to take and more effective than plain mineral oil. Further, by softening the feces, Petrolagar induces large, well formed stools which are easy to evacuate. The five types of Petrolagar afford a choice of medication adaptable to the individual patient. Petrolagar Laboratories, Inc., 8134 McCormick Blvd., Chicago, Illinois.

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65 cc. emulsified with 0.4 Gm. agar  
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## MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

### VENEREAL DISEASE CONTROL PROGRAM

With the aid of \$77,206 granted to Michigan by the United States Public Health Service, the State Department of Health is developing plans for extending and improving the venereal disease control program of the state and local health departments.

The expanded program will be built around the state venereal disease administration which has functioned satisfactorily during the past year with the coöperation of the Michigan State Medical Society's Advisory Committee on Syphilis Control. This program is administered by the Department's Division of Venereal Diseases under the direction of Dr. Russell Pleune, assisted by an investigator and a clerical staff.

Under the new reporting system inaugurated in 1937, syphilis, gonorrhea and chancroid are reportable by name or initials and date of birth to local fulltime health departments. Where such a department does not exist, cases are reportable directly to the Michigan Department of Health. Reporting by name and address is required in (1) lapsed treatment cases; (2) syphilis cases in certain contract occupations at the discretion of the reporting physician; (3) gonorrhea in nurses, nursemaids and domestics; (4) cases failing to coöperate in contract finding; and (5) contracts not under observation.

Special venereal disease investigations are carried on by the director and investigator upon request. Administration of the Antenuptial Physical Examination Law is also vested in this division.

Drugs for the treatment of syphilis—neoarsphenamine, mapharsen and bismuth subsalicylate in oil—are distributed free to physicians for medically indigent patients. These drugs may be obtained through local full-time health departments, or where such do not exist, directly from the Michigan Department of Health.

Laboratory service to physicians in the serodiagnosis of syphilis and microscopy in gonococcic infections is administered by the Bureau of Laboratories. This service is performed free for medically indigent persons. In addition, the state laboratories check approximately 135 registered laboratories at intervals for accuracy and dependability of serodiagnostic tests. Diagnostic examinations for marriage license applicants are made without charge at the state laboratories.

The Department's venereal disease education program has been coördinated through the Bureau of Education. A continuous program of lay education in the cause, prevention and cure of syphilis has been carried on in *Michigan Public Health*, the monthly bulletin of the Department, and in the Journals of coöperating agencies. Within the past year a great new field of venereal disease education, the daily and weekly newspapers, has been exploited. Heretofore, editors have shunned the slightest mention of the "social diseases." The new objective approach to the control of these diseases is reflected in the editor's current widespread use of venereal disease information.

Social hygiene pamphlets distributed free by the Department include "Why Don't We Stamp Out Syphilis?" by Surgeon General Thomas Parran, "Combatting Early Syphilis" by John H. Stokes, M.D., Sex Education in the Home, and Growing Up in the World Today. Professional education pamphlets include Suggested Outlines for the Treatment of Syphilis and Syphilis Treatment Technic, Complications and Reactions. Close coöperation is maintained with the Joint Committee on Health Education which provides a venereal disease lecture service. Department staff members are also available for lecture service upon request.

Around this basic organization the augmented venereal disease control program will be administered with the new federal grant-in-aid. The Michigan Department of Health program will be strengthened by the addition of new personnel including a full-time epidemiologist. The Division of Venereal Diseases will institute a policy of making contacts in all possible cases of infectious syphilis to meet the need for source and contact investigation of such cases.

Drugs for the treatment of syphilis, heretofore provided only for medically indigent cases, will be distributed free for the treatment of *all* cases. To obtain these drugs, case reports will be required. Diagnostic reports from a registered laboratory are not required to obtain drugs.

Diagnostic laboratory service, also provided in the past only for medically indigent cases, will be provided free in all cases of venereal disease under the new program. The Department's laboratory system, which now includes the Western Michigan Division Laboratory at Grand Rapids and the Upper Peninsula Branch at Houghton in addition to the central laboratories at Lansing, will be strengthened by the establishment of a new branch laboratory at

Powers. The Powers laboratory will furnish general diagnostic service to physicians in the eastern part of the Upper Peninsula.

The general educational program of the Department will be broadened by the addition of new venereal disease education materials and services. Institutes will be sponsored for the instruction of nurses of the local health departments in venereal disease nursing. Studies will also be sponsored in selected areas to check on reporting of morbidity and treatment.

Full-time city health departments will also share in the federal subsidy. Funds have been allotted to Grand Rapids, Pontiac, Flint, Lansing, Saginaw, Jackson, Kalamazoo and Detroit. These funds will be used to provide additional venereal disease control services in these communities including the provision of improved diagnostic laboratory services, case and contact follow-up services in coöperation with local physicians, and staff training in venereal disease control.

This augmented venereal disease control program marks but the beginning of the Michigan phase of the national venereal disease campaign authorized under the LaFollette-Bulwinkle Act. This act provides \$3,000,000 for the 1938 program, \$5,000,000 for 1939 and \$7,000,000 in 1940 as well as such funds as may be deemed necessary thereafter. The national program is being administered through the United States Public Health Service.

\* \* \*

#### LABORATORIES REGISTERED FOR SERODIAGNOSIS OF SYPHILIS

The Bureau of Laboratories of the Michigan Department of Health is required by law to check the accuracy and dependability of laboratories making examinations in the control of communicable diseases in Michigan. Since the passage of the Ante-

## SAFE—STERILE—HOME DELIVERIES

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# INGA - O.B. - KITS

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**All worth while laboratory examinations; including—**

**Tissue Diagnosis**

**The Wassermann and Kahn Tests**

**Blood Chemistry**

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**Basal Metabolism**

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**Electrocardiograms**

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Saginaw

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The pathologist in direction is recognized  
by the Council on Medical Education  
and Hospitals of the A. M. A.

nuptial Physical Examination law with its requirement of serologic tests for syphilis on all marriage license applicants, the registration of laboratories has taken on new significance. At least twice each year these laboratories must be check-tested for accuracy and dependability. The current list of laboratories registered for the serodiagnosis of syphilis is published herewith for the information of physicians.

### LABORATORIES IN MICHIGAN REGISTERED FOR THE SERODIAGNOSIS OF SYPHILIS

Corrected to June 23, 1938

*Reg. No. Name of Laboratory*

#### ADRIAN

202 Emma L. Bixby Hospital

#### ANN ARBOR

5 St. Joseph Mercy Hospital

6 University Hospital

127 University Health Service

#### BATTLE CREEK

9 Battle Creek Sanitarium

175 Chemical & Bacteriological

11 L. Y. Post Montgomery Hospital

70 Nichols Memorial Hospital

#### BAY CITY

13 Bay City Health Department

191 Gamble Clinical

211 General Hospital

14 Mercy Hospital

#### BENTON HARBOR

170 Clinical Lab., Mercy Hospital

228 King David Hospital

#### DEARBORN

166 Dearborn Clinical

183 Ford Motor Co. Medical

#### DETROIT

1 Detroit Health Department

220 Angus McLean

195 Brooks

162 Buesser

223 Campbell Clinical

203 Central Laboratories

18 Children's Hospital

100 Clark Clinical

140 Chas. G. Jennings Hospital

17 Delray General Hospital

225 Detroit Medical, Surgical & Dental Gr.

217 Detroit Osteopathic Hospital

164 Detroit X-Ray & Clinical

226 Downtown Clinical

189 East Side General Hospital

201 East Side Medical

227 Edyth K. Thomas Memorial Hospital

198 Ellwart Clinical

113 Evangelical Deaconess Hospital

156 Fairview Sanatorium

136 Florence Crittenton Hospital

21 Grace Hospital

73 Harper Hospital

176 Havers

22 Henry Ford Hospital

224 Jamieson Allergy & Clinical

188 Jefferson Clinic

199 Jordan Clinical

206 Marr General Hospital

142 Medical Clinical

177 Michigan Bell Telephone Co.

180 Michigan Diagnostic Clinic

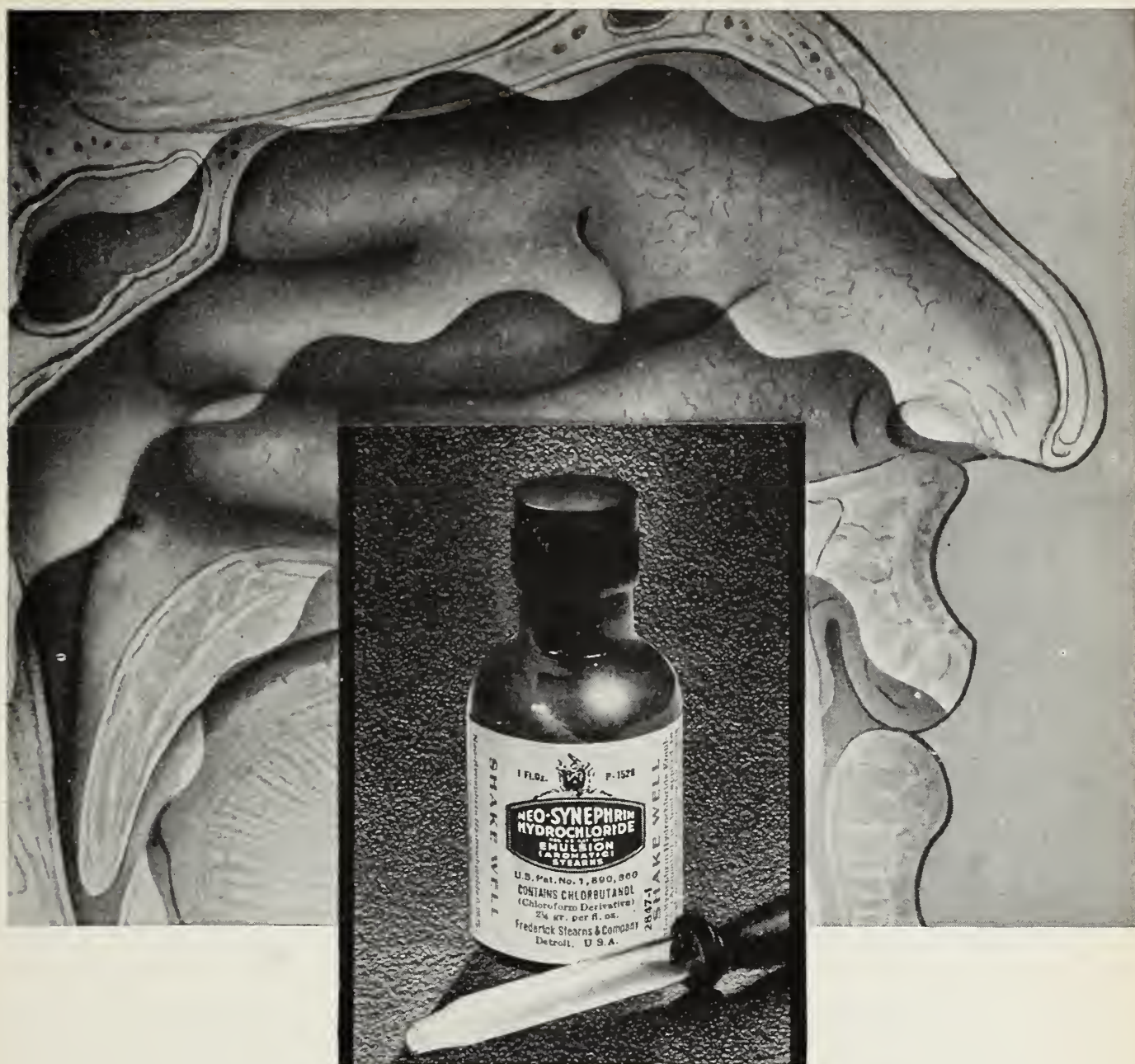
24 National Pathological

157 Nottingham Clinical

25 Owen Clinical

88 Parkside Hospital

(Continued on Page 758)



*It spreads rapidly*  
over a large area

The low surface tension and ready miscibility of Neo-Synephrin Emulsion cause it to spread rapidly and evenly over the nasal mucosa, relieving the discomforting engorgement of colds, rhinitis, hay fever.

The synthetic vasoconstrictor Neo-Synephrin Hydrochloride (laevo-alpha-hydroxy-beta-methyl-

## NEO-SYNEPHRIN Hydrochloride Emulsion

amino-3 hydroxy-ethylbenzene hydrochloride) has a more sustained action than epinephrine or ephedrine, is free from sting, and is so

stable that it may be sterilized by boiling.

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AUGUST, 1938

753



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Ward S. Ferguson, M. D.

James C. Droste, M. D.

Lynn A. Ferguson, M. D.

+

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## DISEASES OF THE RECTUM

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+

Sanitarium Hotel Accommodations

*Reg. No. Name of Laboratory*

(Detroit, Continued)

26 Physicians Service  
27 Providence Hospital  
28 Receiving Hospital  
222 Reveno, Wm. S.  
31 St. Joseph's Mercy Hospital  
32 St. Mary's Hospital  
76 Schaefer  
181 Stafford, Frank  
196 Stafford Biological  
212 Trinity Hospital  
117 Woman's Hospital

ELOISE

97 Seymour Hospital

FLINT

36 Hurley Hospital  
213 Sullivan  
209 St. Joseph Hospital  
112 Women's Hospital  
214 Zimmerman

GRAND RAPIDS

2 West. Mich. Div., Mich. Dept. Health  
167 Allergic & Clinical  
38 Blodgett Memorial Hospital  
40 Brotherhood Private  
37 Butterworth Hospital  
192 Hufford  
41 St. Mary's Clinical  
42 Western Michigan Clinical

GROSSE POINTE

116 Cottage Hospital  
158 Nottingham Clinical

HAMTRAMCK

94 Hamtramck Health Department  
210 St. Francis Hospital

HIGHLAND PARK

44 General Hospital

HOUGHTON

3 Upper Peninsula Division, Mich. Dept. Health

IRON MOUNTAIN

193 Itzov Clinical

JACKSON

146 Jackson Health Department

186 W. A. Foote Memorial Hospital

KALAMAZOO

47 Kalamazoo Health Department

91 Bronson Methodist Hospital

46 New Borgess

LANSING

0 Michigan Department of Health

163 Larkum Clinical

69 St. Lawrence Hospital

LAPEER

125 Lapeer State Home & Tr. School

MARQUETTE

134 St. Luke's Hospital

126 Morgan Heights Sanatorium

MONROE

141 Diagnostic Clinic

104 Mercy Hospital

187 Monroe Hospital

MT. CLEMENS

51 Macomb County

50 St. Joseph Hospital

MUSKEGON

53 Hackley Hospital

54 Mercy Hospital

NILES

118 Pawating Hospital

NORTHVILLE

111 Wm. H. Maybury Sanatorium

OWOSSO

107 Memorial Hospital

*Reg. No. Name of Laboratory*

	PLAINWELL
230	Wm. Crispe Hospital
	PONTIAC
56	Dept. Health & Gen'l Hospital
57	Oakland County Health
128	Pontiac State Hospital
132	St. Joseph's Mercy Hospital
	PORT HURON
200	Port Huron Hospital
58	St. Clair County
	ROSEVILLE
83	Roseville Health Dept.
	SAGINAW
59	Central Laboratory
	SAULT STE. MARIE
154	Chippewa Co. War Mem. Hospital
229	Sault Polyclinic
	SOUTH HAVEN
218	South Haven City Hospital
	ST. JOHNS
108	Clinton Memorial Hospital
168	St. Johns Clinic
	ST. JOSEPH
216	St. Joseph Sanitarium
	STURGIS
182	Sturgis Memorial Hospital
	TRAVERSE CITY
62	Traverse City State Hospital
	WYANDOTTE
63	General Hospital
	YPSILANTI
150	Ypsilanti State Hospital

\* \* \*

**COMMUNICABLE DISEASE  
ADVISORY COMMITTEE**

An advisory committee to the Bureau of Communicable Diseases has been appointed by Commissioner Don W. Gudakunst with the approval of the State Council of Health. Members of the committee will assist Dr. Filip C. Forsbeck, bureau director, in perfecting plans and policies for more effective control of communicable diseases.

The committee members, serving staggered terms of three years each without compensation, include Dr. C. D. Barrett, director of the Ingham County Health Department; Dr. E. E. Martmer, professor of pediatrics at Wayne University; Dr. Allan J. McLaughlin, professor of epidemiology at the University of Michigan; Dr. C. A. Neafie, director of the Pontiac Health Department; Dr. Franklin H. Top, director of the Division of Epidemiology, Detroit Department of Health; and Dr. V. K. Volk, director of the Saginaw County Health Department.

\* \* \*

**POSTGRADUATE OBSTETRICAL  
TRAINING**

Appointments for the special two-week postgraduate training course in obstetrics and gynecology being sponsored by the Bureau of Maternal and Child Health at University Hospital, Ann Arbor, have been announced for the July to September period. Two practicing physicians are awarded scholarships at two-week intervals for this specialized training under the personal direction of Dr. Norman F. Miller, head of the Department of Obstetrics and Gynecology.

The eleven physicians receiving the scholarships for the quarter beginning July 6 include Dr. Kenneth W. Dick, Imlay City; Dr. Donald K. Barstow, St. Louis; Dr. O. F. Jens, Essexville; Dr. C. F. Dubois, Alma; Dr. Louis Kazdan, Midland; Dr. Clarke Dorland, Lapeer; Dr. A. D. Hobbs, St. Louis; Dr. H. M. Best, Lapeer; Dr. J. O. Thomas, North Branch; Dr. L. S. Dunkin, Greenville; and Dr. J. A. VanLoo, Belding.

AUGUST, 1938

## Cook County Graduate School of Medicine

(In affiliation with COOK COUNTY HOSPITAL)

Incorporated not for profit

### ANNOUNCES CONTINUOUS COURSES

**MEDICINE**—Special Courses During August Including Electrocardiography and Heart Disease. Gastro-Enterology in August and October.

**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technique with practice on living tissue; Clinical Courses; Special Courses. Courses start every Monday.

**GYNECOLOGY**—One Month Personal Course starting August 22nd. Two Weeks Course starting October 10th. Gynecological Pathology by Dr. Schiller starting October 24th.

**OBSTETRICS**—Two Weeks Intensive Course starting October 24th. Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course every week; Intensive Formal Course starting October 3rd.

**DERMATOLOGY AND SYPHILOLOGY**—Two Weeks Special Course starting September 19th. Clinical Courses starting every week.

**CYSTOSCOPY**—Ten-day Practical Course rotary every two weeks.

General, Intensive and Special Courses in all branches of Medicine, Surgery and the Specialties every week.

**TEACHING FACULTY**—Attending Staff  
of Cook County Hospital

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# ◆ General News and Announcements ◆

## THE ONE HUNDRED PER CENT CLUB OF THE MICHIGAN STATE MEDICAL SOCIETY

1. Barry County Medical Society
2. Cass County Medical Society
3. Chippewa-Mackinac County Medical Society
4. Clinton County Medical Society
5. Delta County Medical Society
6. Dickinson-Iron County Medical Society
7. Eaton County Medical Society
8. Gogebic County Medical Society
9. Hillsdale County Medical Society
10. Houghton-Baraga-Keweenaw County Medical Society
11. Ingham County Medical Society
12. Jackson County Medical Society
13. Lapeer County Medical Society
14. Lenawee County Medical Society
15. Livingston County Medical Society
16. Luce County Medical Society
17. Manistee County Medical Society
18. Mecosta-Osceola County Medical Society
19. Menominee County Medical Society
20. Midland County Medical Society
21. Muskegon County Medical Society
22. Newago County Medical Society
23. O.M.C.O.R.O. County Medical Society
24. Oceana County Medical Society
25. Ontonagon County Medical Society
26. Ottawa County Medical Society
27. Saginaw County Medical Society
28. St. Clair County Medical Society
29. Schoolcraft County Medical Society
30. Shiawassee County Medical Society
31. Tuscola County Medical Society
32. Wexford-Kalkaska-Missaukee County Medical Society.

The list of county medical societies which have recorded 100 per cent paid membership for the year 1938 is growing. Is your society listed above? Several societies have reported dues for all their members except one or two. If your dues are still unpaid, please contact your county secretary today; you may be able to put your society in the 100 per cent classification.

*T. J. Carney, M.D.*, of Alma, has been elected District Governor of Rotary. Congratulations!

\* \* \*

A "Conference on Rural Medicine" will be held in Cooperstown, N. Y., on October 7-8, 1938, at the Mary Imogene Bassett Hospital.

\* \* \*

Please advise the Placement Bureau, 2020 Olds Tower, Lansing, if you know of a community where a young physician might locate.

\* \* \*

*Carleton B. Peirce, M.D.*, of Ann Arbor, has accepted an appointment as Chief of the Department of Radiology at the Royal Victoria Hospital in Montreal, Quebec. Congratulations!

\* \* \*

A small hospital in a city in Tuscola County is available for lease or purchase. For further particulars, write the Executive Office, 2020 Olds Tower, Lansing.

\* \* \*

The Michigan State Board of Registration in Medicine gave notice on July 11, 1938, that it revoked the medical licensure of Leo Charles Donnelly, Detroit, as of June 16, 1938.

\* \* \*

*Geo. C. Stucky, M.D.*, has been appointed Director of the Eaton County Health Department, effective September 1. His headquarters will be in Charlotte, Michigan. Congratulations, Dr. Stucky!

The Upper Peninsula Medical Society Meeting will be held at Sault Ste. Marie on Thursday and Friday, August 18-19. The complete program was published in the July M.S.M.S. JOURNAL, page 666.

\* \* \*

Copies of "What Everyone Should Know About Cancer"—a booklet prepared this year by the Michigan State Medical Society Cancer Committee—are available by writing 2020 Olds Tower, Lansing.

\* \* \*

*Dr. Basil L. Connelly* and *Mrs. F. L. McFadden*, both of Detroit, were married on June 27th at Harbor Beach. The bride is the daughter of *Mrs. Lewis Ludington* and the late *Captain Ludington*.

\* \* \*

Write for hotel reservations today if you plan to attend the 1938 M.S.M.S. Convention in Detroit next September. It is anticipated that 2,000 physicians will register.

\* \* \*

*Roy H. Holmes, M.D.*, Muskegon, was guest speaker at a recent Muskegon County Health Rally sponsored by the rural Parent-Teachers. Dr. Holmes gave an illustrated lecture on Syphilis Control.

\* \* \*

*Afflicted Children*: June, 1938, 1,973 cases of which 1,691 went to miscellaneous hospitals and 282 went to University Hospital.

*Crippled Children*: June, 1938, 476 cases, of which 299 went to miscellaneous hospitals, and 177 went to University Hospital.

\* \* \*

The third International Goiter Conference will be held under the auspices of the American Association for the Study of Goiter in Washington, D. C., September 12-13-14, Mayflower Hotel. For program write Dr. W. Blair Mosser, Secretary, Kane, Pennsylvania.

\* \* \*

Be sure of the drugs you prescribe to your patients. Don't take a chance and prescribe untested, and perhaps dangerous products. All pharmaceuticals advertised in the pages of THE JOURNAL of the M.S.M.S. have been tested and approved. Patronize firms who advertise their tested and approved products in THE JOURNAL.

\* \* \*

Important dates to remember:

September 13, 1938—General Primary Election.

November 8, 1938—General Election.

One hundred and thirty-two Michigan legislators, and some thirty-two U. S. Senators and four hundred thirty-five Congressmen will be elected. All persons engaged in business enterprises must be actively concerned in this year's election. This very definitely includes doctors of medicine.

\* \* \*

Honorary, Retired, Emeritus and Associate Membership in the M.S.M.S.: Please certify to the Executive Office, 2020 Olds Tower, Lansing, at least thirty days in advance of the annual meeting (no later than August 19), the names of any of your members for whom Special Memberships in the State Society will be sought next September. The membership records of physicians, recommended by county medical societies for special memberships, must be checked before final submission to the House of Delegates.



# INTERNATIONAL MEDICAL ASSEMBLY



**Inter-State Postgraduate Medical Association of North America**  
Public Auditorium, Philadelphia, Pa. **OCTOBER 31, NOVEMBER 1, 2, 3, 4, 1938**

Pre-assembly clinics, October 29; Post-assembly clinics, November 5, Philadelphia hospitals  
President, Dr. Elliott P. Joslin; President-Elect, Dr. George W. Crile  
Chairman, Program Committee, Dr. George W. Crile; Managing-Director, Dr. William B. Peck  
Secretary, Dr. Tom B. Throckmorton; Director of Exhibits, Dr. Arthur G. Sullivan  
Treasurer and Director Foundation Fund, Dr. Henry G. Langworthy  
Chairman, Philadelphia Committees, Dr. Louis H. Clerf

**ALL MEDICAL MEN AND WOMEN IN GOOD STANDING CORDIALLY INVITED**

Intensive Clinical and Didactic program by world authorities  
The following is a major list of members of the profession who will take part on the program:

Alfred W. Adson, Rochester, Minn.  
Walter C. Alvarez, Rochester, Minn.  
Wayne Babcock, Philadelphia, Pa.  
Claude S. Beck, Cleveland, Ohio  
George Blumer, New Haven, Conn.  
Peter T. Bohan, Kansas City, Mo.  
William F. Braasch, Rochester, Minn.  
Richard B. Cattell, Boston, Mass.  
Henry A. Christian, Boston, Mass.  
Arthur C. Christie, Washington, D. C.  
Edward D. Churchill, Boston, Mass.  
Dr. Louis H. Clerf, Philadelphia, Pa.  
W. McK. Craig, Rochester, Minn.  
George W. Crile, Cleveland, Ohio  
John S. Coulter, Chicago, Ill.  
Elliott C. Cutler, Boston, Mass.  
Walter E. Dandy, Baltimore, Md.  
William Darrach, New York, N. Y.  
Vernon C. David, Chicago, Ill.  
Loyal Davis, Chicago, Ill.  
Robert S. Dinsmore, Cleveland, Ohio  
Claude F. Dixon, Rochester, Minn.  
Nicholson J. Eastman, Baltimore, Md.  
Edmond M. Eberts, Montreal, Canada  
E. L. Eliason, Philadelphia, Pa.  
Charles A. Elliott, Chicago, Ill.  
John F. Erdmann, New York, N. Y.  
Clarence B. Farrar, Toronto, Canada  
John R. Fraser, Montreal, Canada  
John C. Gittings, Philadelphia, Pa.  
Russell L. Haden, Cleveland, Ohio

William D. Haggard, Nashville, Tenn.  
George A. Harrop, New York, N. Y.  
Charles G. Heyd, New York, N. Y.  
Fred J. Hodges, Ann Arbor, Mich.  
Chevalier Jackson, Philadelphia, Pa.  
Chevalier L. Jackson, Philadelphia, Pa.  
Elliott P. Joslin, Boston, Mass.  
Frederick J. Kalteyer, Philadelphia, Pa.  
Floyd E. Keene, Philadelphia, Pa.  
Herman L. Kretschmer, Chicago, Ill.  
Frank Lahey, Boston, Mass.  
Dean Lewis, Baltimore, Md.  
Walter I. Lillie, Philadelphia, Pa.  
Perrin H. Long, Baltimore, Md.  
Warfield T. Longcope, Baltimore, Md.  
William E. Lower, Cleveland, Ohio.  
Charles W. Mayo, Rochester, Minn.  
Irvine McQuarrie, Minneapolis, Minn.  
James H. Means, Boston, Mass.  
Arthur R. Metz, Chicago, Ill.  
William S. Middleton, Madison, Wis.  
John J. Moorhead, New York, N. Y.  
George P. Muller, Philadelphia, Pa.  
Clay Ray Murray, New York, N. Y.  
John H. Musser, New Orleans, La.  
Howard C. Naffziger, San Francisco, Cal.  
Frank R. Ober, Boston, Mass.  
Eric Oldberg, Chicago, Ill.  
Oliver S. Ormsby, Chicago, Ill.  
Hubley R. Owen, Philadelphia, Pa.  
Wilder Penfield, Montreal, Canada

George E. Pfahler, Philadelphia, Pa.  
Fred W. Rankin, Lexington, Ky.  
Robert F. Ridpath, Philadelphia, Pa.  
David Riesman, Philadelphia, Pa.  
Leonard G. Rowntree, Philadelphia, Pa.  
Thomas H. Russell, New York, N. Y.  
E. Kost Shelton, Los Angeles, Cal.  
Fred M. Smith, Iowa City, Iowa  
Marius N. Smith-Petersen, Boston, Mass.  
Alfred Stengel, Philadelphia, Pa.  
Charles Stockard, New York, N. Y.  
Cyrus C. Sturgis, Ann Arbor, Mich.  
Robert G. Torrey, Philadelphia, Pa.  
William G. Turner, Montreal, Canada  
Professor von Eicken, Berlin, Germany  
Waltman Walters, Rochester, Minn.  
G. Harlan Wells, Philadelphia, Pa.  
Allen O. Whipple, New York, N. Y.  
Paul D. White, Boston, Mass.  
Hugh H. Young, Baltimore, Md.

## TENTATIVE FOREIGN ACCEPTANCES:

Rt. Hon. Lord Horder, London, England  
Mr. A. Lawrence Abel, F.R.C.S., London, England  
Sir John Fraser, Edinburgh, Scotland  
Professor Mario Donati, Milan, Italy  
Professor Roberto Alessandri, Rome, Italy  
Professor Ferdinand Sauerbruch, Berlin, Germany

**HOTEL HEADQUARTERS**  
Benjamin Franklin Hotel

## HOTEL RESERVATIONS

Hotel Committee, Mr. T. E. Willis, Chairman, Chamber of Commerce Bldg., 12th and Walnut Sts., Philadelphia, Pa.

Final program mailed to all members of the medical profession in good standing, September 1.

If you do not receive one, write the Managing-Director.

Comprehensive Scientific and Technical Exhibit. Special Entertainment for the Ladies.



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\* \* \*

J. M. Robb, M.D., of Detroit, has been invited to give an instructional course on "Tonsillectomy and Adenoidectomy and Their Complications" at the National Academy of Ophthalmology and Otolaryngology, Mayflower Hotel, Washington, D. C., October 9 to 14.

Dr. Robb has also been invited to be guest speaker at the American College of Surgeons meeting in New York City on October 18, at the Waldorf-Astoria.

\* \* \*

Michigan winners at the Twenty-fourth Annual Tournament of the American Medical Golfing Association, held in San Francisco on June 13, were Dr. Robert C. Jamieson of Detroit, who turned in the best gross score in the First Flight and was presented with a set of four matched woods, presented by Bill Mennen of The Mennen Company; Dr. Daniel P. Foster of Detroit was winner in the Blind Bogey Event, and was presented with the Atlantic City Trophy, a sterling silver platter, presented by the Hosts of 1937. Congratulations!

\* \* \*

*Fallacious Argument for Socialized Medicine:* All have heard the oft-repeated argument that compulsory education has been a success—why not compulsory sickness insurance or state medicine? Here

we find an inaccurate and misleading false premise: no general federally-controlled education system exists! Moreover, American communities are jealous in their local administration of education; they control selection of teachers, subjects and textbooks. Also teachers fight standardization, mass handling of problems, and attempts of politicians to gain control. In addition, while it may be possible to give information to a group in a school, medical service cannot be given that way. Every patient is a distinct medical personality or question mark.

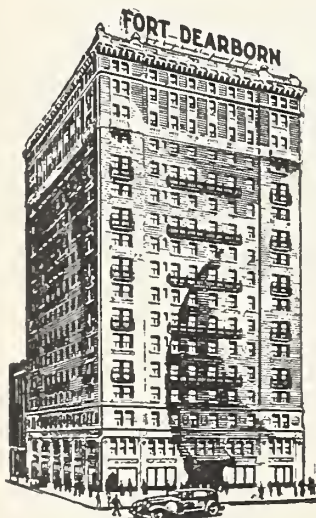
\* \* \*

Oakland County Medical Society's "State Society Night" was held at the Orchard Lake Country Club on July 13. Some seventy-five physicians were present, including the following officers of the Michigan State Medical Society; President Henry Cook, President-elect Henry A. Luce, Secretary L. Fernald Foster, Council Chairman P. R. Urnston, Councilors George A. Sherman, H. R. Carstens, A. S. Brunk, Vice Speaker of the House of Delegates M. H. Hoffmann, and Executive Secretary Wm. J. Burns. Other guests included the speaker of the evening, Mr. Wm. J. Norton, who gave the "Pros and Cons of the Welfare Referendum" and praised Dr. R. G. Tuck for his efficient work as E.R.A. Medical Director of Oakland County. Also present were Drs. C. A. Catherwood, G. L. McClellan, Wm. Woodworth of Detroit, and Mr. Stacy Skelton, E.R.A. Administrator, Oakland County.

\* \* \*

The twenty-third International Assembly of the Inter-State Postgraduate Medical Association of North America will be held in the public auditorium of Philadelphia, Pennsylvania, October 31, November 1, 2, 3 and 4, 1938. All scientific and clinical sessions will take place in the auditorium. Hotel headquarters will be the Benjamin Franklin Hotel.

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The members of the medical profession of Philadelphia are correlating for the clinics an abundance of hospital material representing various types of pathological conditions which will be discussed by the contributors to the program.

In the neighborhood of eighty distinguished teachers and clinicians will appear on the program, a tentative list of which may be found in the advertising section of this JOURNAL. The subjects and speakers have been selected to consider practically all the subjects of greatest interest to the medical profession in general.

A full program of scientific and clinical sessions will take place every day and evening of the Assembly, starting each morning at 8:00 o'clock.

The Association, through its officers, including Drs. Elliott P. Joslin, Boston, Mass.; Dr. George W. Crile, Cleveland, Ohio, and Dr. William B. Peck, Freeport, Ill., extend a very hearty invitation to all members of the profession in good standing in their State and Provincial Societies to attend the Assembly. The registration fee is \$5.00.

\* \* \*

*Michigan physicians*, members of the State Society, who registered at the San Francisco meeting of the A.M.A., included: Drs. James R. Adams, Dearborn; Samuel S. Altshuler, Detroit; Meyer S. Ascher, Detroit; F. A. Baker, Pontiac; I. B. Barnwell, Ann Arbor; H. S. Broderson, River Rouge; I. D. Brook, Grandville; E. H. Campbell, Newberry; W. L. Casler, Marquette; F. A. Collier, Ann Arbor; L. G. Christian, Lansing; H. S. Collisi, Grand Rapids; J. W. Conn, Ann Arbor; T. B. Cooley, Detroit; F. P. Currier, Grand Rapids; I. G. Downer, Detroit; Glenn E. Drewyer, Flint; D. C. Durman, Saginaw; L. L. Ely, Grosse Pointe Park; Aaron Farbman, Detroit; M. Z. Feldslein, Detroit; Wm. Fiedling, Norway; N. W. Flaherty, River Rouge; D. P. Foster, Detroit; Leon A. Fox, Ann Arbor; Mary M. Frazer, Detroit; R. H. Freyberg, Ann Arbor; F. B. Gerls, Pontiac; S. E. Gould, Eloise; T. R. K. Gruber, Eloise; F. Walter Hall, Detroit; F. W. Hartman, Detroit; Clyde K. Hasley, Detroit; Parker Heath, Detroit; N. W. Heysett, Hart; John N. Holcomb, Grand Rapids; Philip L. Howard, Detroit; M. R. Huffman, Milford; R. C. Jamieson, Detroit; I. Jerome Hauser, Ann Arbor; Edgar Kahn, Ann Arbor; Reuben L. Kahn, Ann Arbor; Mana Kessler, Bay City; Saba Kessler, Bay City; C. R. Keyport, Grayling; D. K. Kitchen, Detroit; T. Kolvoord, Battle Creek; John Lavan, Grand Rapids; George L. LeFevre, Muskegon; O. W. Lohr, Saginaw; H. A. Luce, Detroit; E. G. Martin, Detroit; R. A. MacArthur, Detroit; F. M. Meader, Detroit; Carey P. McCord, Detroit; Malcolm McPhail, Detroit; Norman F. Miller, Ann Arbor; R. M. Nesbit, Ann Arbor; Rudolf J. Noer, Detroit; John K. Ormond, Detroit; Max M. Peet, Ann Arbor; Grover C. Penberthy, Detroit; R. A. Perkins, Detroit; Joel B. Peterson, Detroit; J. P. Pratt, Detroit; Clara V. Radabaugh, Battle Creek; H. E. Randall, Flint; V. Robson, Berrien Springs; Paul Roth, Battle Creek; R. C. Rueger, Detroit; David I. Sandweiss, Detroit; Victor Scheling, Detroit; L. J. Schermerhorn, Grand Rapids; Frederic Schreiber, Detroit; Carlisle F. Schroeder, Detroit; H. M. Pollard, Ann Arbor; Loren W. Shaffer, Detroit; L. E. Showalter, Cadillac; M. E. Smalley, Ann Arbor; F. Janney Smith, Detroit; Emil Sorock, Detroit; R. H. Stevens, Detroit; C. A. Stinson, Eaton Rapids; Bela T. Szappanyos, Detroit; John F. Tolan, Ann Arbor; Harry A. Towsley, Ann Arbor; M. J. Uloth, Orionville; E. Gifford Upjohn, Kalamazoo; P. R. Urmston, Bay City; F. L. Waters, Detroit; Paul W. Willits, Grand Rapids; also Mr. James E. Bechtel, Detroit, and Mr. Wm. J. Burns, Lansing.

AUGUST, 1938

## Behind MERCUROCHROME

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## THE AMERICAN COLLEGE OF PHYSICIANS

The Twenty-Third Annual Session of the American College of Physicians will be held in New Orleans, with general headquarters at the Municipal Auditorium, March 27-31, 1939. Dr. William J. Kerr of San Francisco is president of the College and will have charge of the program of general scientific sessions. Dr. John H. Musser of New Orleans has been appointed General Chairman of the Session, and will be in charge of the program of clinics and demonstrations in the hospitals and medical schools and of the program of round table discussions to be conducted at the headquarters.

## Among Our Contributors

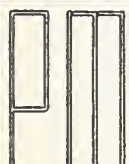
**Dr. Richard C. Connelly** was graduated from St. Louis University in 1924 and interned at Detroit Receiving and Herman Keifer Hospitals. He has served on the staffs of Receiving and Children's Hospital of Michigan and is, at present, a member of the Out-patient Staff of Harper and Consulting Staff of Herman Keifer Hospitals. He is an instructor of Medicine of Wayne University. Dr. Connelly took post-graduate work in gastro-enterology at the University of Pennsylvania Graduate School of Medicine.

\* \* \*

**Dr. Moses Cooperstock** was graduated from Yale College in 1923 and received his M.D. from Yale University Medical School. He was Assistant Professor of Pediatrics at the University of Michigan Medical School from 1931 to 1938, and is at present pediatrician at the Northern Michigan Children's Clinic at Marquette, Michigan. Dr. Cooperstock is a Fellow of the American Academy of Pediatrics and a Licentiate of the American Board of Pediatrics.

\* \* \*

**Dr. Barney A. Credille** is a graduate of Tulane University School of Medicine, 1918. He served internships at the Ancon Hospital, Canal, June 1919 and 1920 at Children's Hospital, also at Washington, 1921-1922. He pursued post-graduate work at the New York Post Graduate School and Hospital. His practice in New York was devoted to allergy. Dr. Credille is a member of Delta Tau Delta and Alpha Kappa Kappa fraternities.



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## IN MEMORIAM

**Dr. Stanley O. Newcomb**

Dr. Stanley O. Newcomb of Ida, Michigan, died on July 27, 1938. He was born in Carleton, Michigan, February 16, 1877. In 1904 he was graduated from the Detroit College of Medicine and entered general practice in Ida, Michigan, where he remained until his death. Dr. Newcomb was a Spanish War veteran, a member of the Monroe County, Michigan State and American Medical Associations. He leaves a wife, Mrs. Elizabeth Newcomb, and daughter, Margaret. A son died last December during his second year in medical college.

**JOUR. M.S.M.S.**

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## THE DIAGNOSIS OF THE RIGHT LOWER QUADRANT

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While appendicitis is by far the commonest surgical lesion of the right lower quadrant of the abdomen, it is important to bear in mind that this region is also the site of numerous other affections which may simulate appendicitis. Moreover, symptoms in the right lower quadrant may attract attention to pathologic conditions situated elsewhere. Some of these conditions require no surgical treatment and others demand operations of considerable magnitude. Some of them are of frequent occurrence and others are exceedingly uncommon. In some cases it will be impossible to differentiate between appendicitis and either a non-surgical condition or one on the other hand which requires involved operative treatment.

The surgeon who exercises the most diligent preoperative study of his patient will be the one who is least frequently surprised at operation. Moreover, he who operates for appendicitis should always be aware of the fact that not only may surgical operations for appendicitis be very difficult indeed, but also that unexpected conditions may sometimes be encountered which will require resection of the right colon or other serious procedures. In case the surgeon finds a normal appendix he should have in mind what lesions to look for which might explain the clinical picture.

A complete history, careful physical examination, and the help of the laboratory and the x-ray department will go a long way toward making a definite diagnosis. Pain must be carefully evaluated. Its duration, migration, intensity, character, and radiations are of first importance. The elicitation of localized tenderness may require considerable patience and resourcefulness, particularly in a young child. The

writer always carries a picture of a bear to intrigue his juvenile patient and divert his attention while abdominal palpation is being carried out. The site of the suspected tender area will always be examined last and only after that will rebound tenderness be tested. Examination is usually more easily carried out if the patient's knees are flexed. The examining hand must be warm and gentle.

The demeanor of the patient is very informative. He who has peritoneal irritation or a frank peritonitis will lie quietly in bed, whereas he who suffers from renal colic is restless and twists about in a vain effort to get relief from his pain. Where the lesion is in the abdominal wall, contraction of the abdominal muscles is painful. In intestinal obstruction the acme of the pain is coincident with the loudest borborygmus heard on auscultation.

In most cases of acute appendicitis the diagnosis offers little difficulty. Localized tenderness in the right lower quadrant, pain usually at first near the umbilicus but later in the right lower quadrant, rigidity in the



region of the inflamed appendix, usually emesis, quiet posture, leukocytosis and exclusion of other entities generally suffices to make the diagnosis. It must be remembered, however, that acute appendicitis may occur in the pelvis or on the left side of the abdomen. In the former case a pelvic examination will usually elicit pelvic tenderness. In the latter case a right apex beat will suggest a transposition of the viscera. In chronic appendicitis the pain is milder and is recurrent. Nausea may appear periodically. Localized tenderness is found. The gastro-intestinal x-ray examination is of little if any value in these cases. In appendiceal abscess the outstanding finding is a tender mass in the right lower quadrant or pelvis with a history suggesting a previous recent attack of acute appendicitis.

In cases of calculus of the ureter there may be marked pain, tenderness and rigidity in the right lower quadrant, together with vomiting and leukocytosis. The pain is more severe, however, than that of appendicitis and its onset more abrupt. In renal calculus the pain may be posterior under the twelfth rib or in the flank. In both ureteral and renal calculus the pain is referred to the genitalia or down the anterior aspect of the thigh. Vomiting is a common symptom. Gross or microscopic blood is found in the urine and the intravenous or retrograde urogram is of value.

In movable kidney the pain (Dietl's crisis) is sudden in onset and may be very intense. It is in the kidney region but may be referred down the ureter. It is accompanied by vomiting and even shock. During the attack there is a diminution of the amount of urine passed, but the urine is usually normal in character. There is an absence of fever and leukocytosis.

In infections of the kidney pelvis (pyelitis) there is usually fever, often as high as 102 or 103 degrees, and pus in the urine. If, however, the ureter is occluded by stone, mucous plug, or edema, a retention of urine in the kidney pelvis will take place (hydronephrosis, pyonephrosis). In this event there will be marked tenderness at the angle formed by the 12th rib and spine. Severe pain may be present in the kidney region or the right lower quadrant. Vomiting and leukocytosis are present and often a marked rigidity. It must be remembered that pus may be absent from the urine in these cases due to complete blocking of the ureter, in

which event the diagnosis of appendicitis is usually justifiable.

Mesenteric lymphadenitis is primarily a disease of young children and may often be indistinguishable from appendicitis. There is marked abdominal pain which may be localized, to some extent, in the right lower quadrant. Tenderness and rigidity may be marked. The vomiting, leukocytosis and fever add to the difficulty of the differential diagnosis. The resemblance to appendicitis usually makes laparotomy the safest course.

In acute gonorrheal salpingitis there is pain, tenderness and rigidity of the lower abdomen above the symphysis. It may be midline or more to one side or the other. Leukocytosis is moderate and vomiting is uncommon. Fever is often present. Usually there is a vaginal discharge and the cervical smear will be positive for gonococci. On pelvic examination pressure upon the cervix produces pain and there is tenderness in the fornices.

In ruptured ectopic pregnancy the symptoms vary according to the age of the rupture. During rupture of the pregnancy there is a sharp lancinating pain in the lower abdomen which may be more on one side or the other. The cervix is extremely sensitive to movement, and a tender mass may be palpated in the pelvis. Anomalous menstruation is present and the vaginal bleeding may be constant or intermittent. After rupture the signs and symptoms become increasingly those of a severe internal hemorrhage. There will be pallor, thirst, rapid thready pulse and low blood pressure. The abdomen is tender and rigid and presently becomes distended. Rarely a blue discoloration about the umbilicus (Cullen's sign) may be a clue to the presence of blood in the peritoneal cavity.

Right ovarian cyst with a twisted pedicle produces very severe pain of sudden onset. The patient is usually more restless than one with acute appendicitis. Rigidity, tenderness, vomiting and leukocytosis are present. On pelvic examination a tender cystic mass is palpated. Moderate shock is often present.

Acute intussusception is primarily a disease of childhood and commonly starts in the right lower quadrant. The characteristic features are periodic very severe colicky pains, vomiting and bloody mucus in the rectum. The latter may be discovered only by digital examination or it may be evident



upon defecation. In some 60 per cent of the cases a palpable tumor, usually on the right side of the abdomen, is present. The barium enema not only assists in the diagnosis, but occasionally may reduce the intussusception. Chronic intussusception is rare, occurs chiefly in adults and is evidenced by a firm mass usually in the right lower quadrant of the abdomen. The gastro-intestinal x-ray will be of value in the diagnosis.

Acute colitis is seldom confused with a surgical abdominal condition. Although there may be cramplike pain, vomiting, and tenderness, there is little if any rigidity or localization, and diarrhea is a constant finding.

Early carcinoma of the cecum often suggests chronic appendicitis. The vague pain and tenderness in the right lower quadrant is of gradual onset and is unaccompanied by leukocytosis. There is a progressive loss of weight and strength and an anemia. There is a definite variation from the normal bowel habits. As the carcinoma grows, a mass in the right lower quadrant becomes evident and the anemia may reach 30 per cent hemoglobin and 1,300,000 erythrocytes. The diagnosis is made practically certain by the x-ray with contrast media. In some of the later cases ulceration through the wall of the bowel may cause peritoneal irritation with tenderness and rigidity.

Hemorrhage from a corpus luteum of the ovary will cause a very severe pain in the lower abdomen. The patient maintains a quiet posture and the lower abdomen is tender and rigid. Leukocytosis is present, but fever and vomiting are usually absent. The bleeding may be so profuse as to bring about signs of internal hemorrhage. Pelvic examination is unreliable.

Endometriosis may cause the formation of a "chocolate" cyst of the ovary. Rupture of such a cyst may occur during menstruation and is accompanied by a sudden severe pain in the lower abdomen. The pain may pass away entirely after an hour or two, but marked rigidity remains. The leukocyte count is elevated and a pelvic examination may show a little resistance on one side or the other but little if any tenderness.

Cholecystitis may attract attention to the right lower quadrant. A markedly distended and inflamed gall bladder may show a relative absence of symptoms in the right upper quadrant, but in the right lower

quadrant there will be pain, tenderness, rigidity and a palpable mass. The additional finding of leukocytosis may make the picture very similar to that of appendicitis.

Regional ileitis is of rather slow onset (three to four weeks) and is accompanied by moderately severe colicky pain in the right lower quadrant. Loss of weight, diarrhea, anorexia, and leukocytosis are usually present. In the typical case a slightly tender movable mass may be palpated. The x-ray findings are generally characteristic.

In some cases of intestinal obstruction the predominant symptoms may be in the right lower quadrant. Adhesions, and rarely carcinoids, involving the terminal ileum, may produce pain, tenderness, and rigidity in the right lower quadrant in addition to vomiting and positive x-ray findings on the "scout" film.

Diverticulitis of the cecum is uncommon. It is characterized by right lower quadrant pain which has developed over several days, tenderness, leukocytosis, moderate rigidity and relative absence of nausea and vomiting. The symptoms and signs may be very similar to that of acute appendicitis.

Affections of the urinary bladder occasionally may have symptoms which suggest right lower quadrant pathology. In cystitis there is lower abdominal pain, frequent painful urination and pyuria. In vesical calculus the symptoms may be much the same, but the outstanding finding in the urine is blood rather than pus. Cystoscopy will be illuminating in either case and the x-ray will be positive in vesical calculus.

The diagnosis of mesenteric thrombosis or embolism may be very difficult. The pain is severe and usually not localized. Vomiting is nearly always present. The condition may be present for up to 10 days without really definite symptoms. There is little tenderness or rigidity. The abdominal cavity may contain fluid and a bloody diarrhea may be present. The presence of a vegetative endocarditis may furnish a clue to the presence of embolism.

In actinomycosis the pain and tenderness is similar to that of appendicitis. The finding of a spontaneous sinus of the abdominal wall or of an intestinal fistula or of an abscess is highly suggestive. The demonstration of the ray fungus and the sulphur granules confirms the diagnosis.

Amebic abscess may occur in the right



lower quadrant as the result of a localized amebic invasion and destruction of the cecal wall. The pain is of slower evolution than that of acute appendicitis. There is a tender mass in the right lower quadrant and the leukocytosis may be high (20,000 to 35,000). An important clue is the persistent diarrhea, and the diagnosis is made positive by finding the *endameba histolytica* in the stools or in the discharge from the fecal fistula formed after the abscess.

Right-sided pneumonia may simulate an acute intra-abdominal lesion. Usually, however, the respiratory rate is increased and is of the abdominal type unless the diaphragm is involved. The fever is generally higher than that of appendicitis, being 101 degrees or higher. On auscultation of the chest positive findings are usually present, but may occasionally be absent. The right abdomen may present marked rigidity involving the entire extent of the rectus abdominis muscle. A leukocytosis is present and is higher (30,000) than that of appendicitis. The chest x-ray is usually very helpful in making the differential diagnosis.

In perforated duodenal ulcer, and occasionally perforated gastric ulcer, the intestinal contents may gravitate down along the right colon and accumulate in the region of the appendix, directing attention to this point. The history of sudden onset and the marked severity of the pain, together with "board-like" rigidity are important. Leukocytosis is present and occasionally there will be a pneumoperitoneum.

Meckel's diverticulum becomes of surgical interest by inflammation, perforation of an ulcer or hemorrhage from an ulcer. The latter condition is usually silent. In Meckel's diverticulitis there is abdominal

pain of inconstant location, but often in the right lower quadrant, tenderness, rigidity and leukocytosis. A mucosal polyp at the umbilicus may furnish a clue. In perforation of an ulcer of a Meckel's diverticulum the findings are similar except the rigidity is more marked and pneumoperitoneum may be present.

Herpes zoster may closely simulate acute appendicitis. There may be marked pain and abdominal tenderness, and even occasionally rigidity. Tenderness along the courses of the spinal nerves is an important finding, and three or four days after the onset the characteristic skin lesions will be present.

Hemorrhage into or beneath the right rectus abdominis muscle may produce symptoms indistinguishable from an intra-abdominal surgical condition. Hemorrhage beneath the muscle against the peritoneum is most likely to simulate a "surgical abdomen." The pain and tenderness is marked and is centered over the muscle. A history of direct violence is suggestive, but may be entirely absent, as the hemorrhage may result from muscular exertion. The finding of discoloration of the abdominal skin is important evidence. Surgical exploration may be necessary to make the diagnosis certain.

Quite a number of rare conditions will cause pain, tenderness, or mass in the right lower quadrant. These include intussusception of the appendix, phlegmon of the abdominal wall, osteomyelitis of the ilium, psoas abscess, diverticulum of the bladder, tumor of the pelvic bone, tuberculosis of the cecum, aneurysm of the iliac artery, polyposis of the cecum, and carcinoma of the stomach with extreme dilatation.

## PLASTIC SURGERY IN RELATION TO MOTOR ACCIDENTS\*

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The number of motor driven vehicles registered in the United States has increased almost forty per cent during the last decade. The incidence of motor accidents has followed this increase and the annual toll has become alarming.

The speed of the automobile is far greater now than it was ten years ago, and with the increase in speed, safety devices have not been developed to safeguard the drivers and the passengers. Experimental traffic regulation studies are being carried on, but, as yet, the problem remains unsolved. Changes in the design and structure of the automobile have been accompanied with characteristic types of injuries. Broken wrists were common before the self starter was invented. The advent of the bumper was followed by many broken knees and legs. Today we are confronted with certain types of injuries that have resulted from the change in design of the interior of the automobile as well as its mechanics, for example, high speed motors, transmissions, and hydraulic brakes. Unfortunately, the exposed portions of the human anatomy, chiefly the face, head and neck, are most often injured.

The complication of the anatomy and the conspicuousness of the part frequently injured have created a demand for more skill in the treatment of victims of motor accidents. Frequently, the injuries involve not only the exposed parts; internal organs, the brain, and long bones may be involved, and these cases require the assistance of surgeons skilled in their care.

People are more sensitive regarding their appearance than formerly because today people are confronted with a more competitive struggle for existence. The psychological effects of ugly scars and deformities may cause the bearer to lose his economic and social status.

Although injuries of the face constitute only a portion of the casualties, they are vitally important because the special senses are often affected. Facial deformities are conspicuous and the victim is subjected to mental as well as physical distress.

The principles of treatment as outlined in this paper will be confined largely to the care of soft tissue injuries, with a few remarks about injuries of the facial bones.

The proper initial treatment of lacerated wounds lessens the chance of unsightly

scars. A properly closed wound usually will require no further treatment. There are certain factors in the healing of wounds, however, over which the surgeon has no control. The correct treatment of injuries is the greatest safeguard against complications and deformities.

An examination of the patient should precede any type of treatment. The initial examination should be thorough, covering the entire body, beginning with the head and continuing through the extremities. If this procedure is routinely followed, fractures and lacerations, other than those that are obvious, will not be overlooked, and much embarrassment may be avoided.

The examination, of course, follows the usual routine of observation and palpation. Care should be taken not to overlook fractures because of swelling. Palpation should be bilateral for comparison, beginning with the orbital ridges and continuing with the malar, the zygomatic bones and processes, until the whole bony facial structure has been thoroughly investigated. Fractures of the maxilla and the mandible are recognized by intra-oral examination. X-rays are a great aid in establishing the presence of fractures and the position of the fragments. Frequently, however, the x-rays cannot tell the whole story because of the difficulty in obtaining the correct exposure to portray the displacement of the fragments. Other laboratory aids to diagnosis come under special fields—for example, urinalysis and spinal puncture.

Haste may be responsible for disappointment on the part of the operator. Overlooking injuries and subjecting the patient to unnecessary trauma when his condition contra-indicates it may end in disaster and all due to too much haste. The immediate treatment of the injured has to do with

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maintaining a live patient. A carefully sutured lacerated face is useless to a dead patient. If the patient is in shock, heat to the body, stimulants, fluids by vein and all other

Young children and hypersensitive adults must be given a general anesthetic. One per cent novocaine with fifteen minims of adrenalin per ounce gives adequate anesthesia.



Fig. 1. (left) The patient was riding in the front seat of an automobile and was thrown against a rear-view mirror. She received two parallel, irregular lacerations of the right upper eyelid.

Fig. 2. (right) Results obtained after the wounds were excised to make a single one with regular edges. The latter was closed using three layers of sutures.

accepted anti-procedures should be instituted to combat shock. Hemorrhage should be checked. Temporary dressings should be applied to the wounds to avoid added contamination during the first aid treatment. Cultures taken at random from the street dirt have shown the presence of tetanus bacteria in spite of the few horses on the street. It is generally agreed that all the victims of street accidents should be given, immediately, a prophylactic dose of anti-tetanus serum.

Before any procedure is begun for closing wounds, all the usual surgical procedures for cleanliness should be carried out. The field, and this includes a large area, should be free of dirt and hair. Hair bearing areas should be shaved, but care should be taken not to lose the contour and landmarks. After all the dried blood and gross particles have been removed, the skin is thoroughly cleansed with soap and water (tincture of green soap) and this is followed by alcohol. Strong antiseptics are avoided because of the danger of devitalizing fresh tissue. The important fundamentals of debridement are thorough mechanical cleaning of the wound, careful examination of all the pockets of the wound for foreign bodies, and the removal of all blood clots and loose tissue fragments.

Frequently lacerations are so extensive that the length of time required for careful closure contraindicates a general anesthetic.

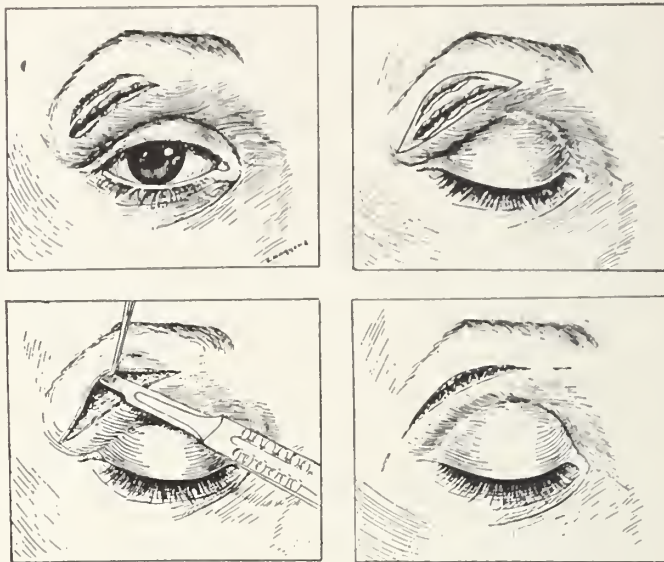


Fig. 3. (above) (a) A sketch of the lacerations shown in Figure 1. (b) An elliptical section of skin was excised as shown.

Fig. 4. (below) (a) The edges of the wound were undermined to allow for ease in closing the wound without any tension on the suture line. (b) The wound is partially open to show the dermal intercuticular sutures in place.

Block and infiltration may be used, depending on the region to be anesthetized.

Hemostasis is as necessary in wounds about the head as elsewhere. Capillary oozing can be controlled with pressure or hot applications. Larger vessels should be clamped and usually no ligature is necessary. Still larger vessels should be isolated, clamped and tied with fine catgut. Small mosquito forceps should be used for isolating the vessels and only the vessel should be tied to avoid necrosis of tissue.

The edges of irregular wounds are excised to straighten them before suturing. (Figs. 1 and 2). Contused wound edges should be excised in order to bring healthy tissue into approximation. Sharp corners should be eliminated because of necrosis which usually follows due to inadequate blood supply.

The excision of the wound edges is done using a sharp scalpel, and great care should be employed to make the fresh skin edges vertical. Bevelled edges may result in keloids and more conspicuous scars. The wound edges are undermined in order to bring them into approximation without tension at the suture line (Figs. 3-a, and b, and Figs. 4-a, and b).

Surgeons for many years have realized



that when human tissue is severed, sewing or suturing is desirable to maintain the edges of the opening in their proper position until healing has progressed to the point where such support is no longer needed.

marks." The proper closure of a facial wound is done by first using deep subcutaneous interrupted sutures (Figs. 5 and 6). Fine dermal material is used and the knot is inverted into the depth of the wound. The

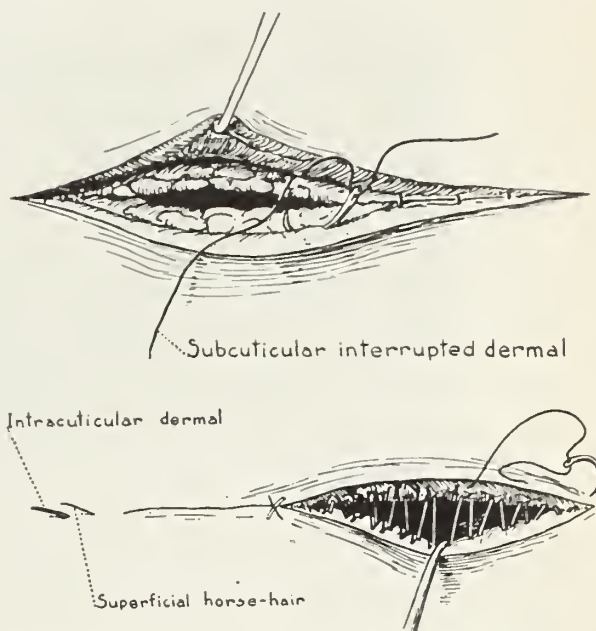
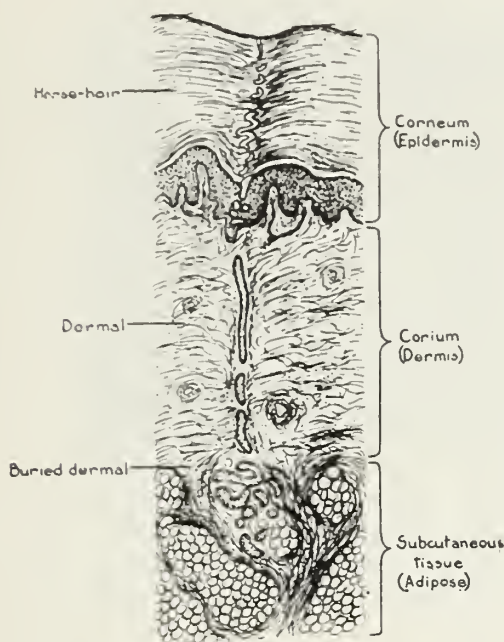


Fig. 5. (left) A drawing to show the layers of the skin and the level in which the three types of sutures are placed.

Fig. 6. (upper right) Interrupted fine dermal sutures placed at a level just below the corium. The knots are placed at the lower part of the suture.

Fig. 7. (lower right) The intra (or inter) cuticular dermal is placed in the dermis. The superficial layer of horse hair is placed in the epidermis. These are continuous sutures laced back and forth the entire length of the wound, coming to the outside about every  $1\frac{1}{4}$  inches to facilitate removal.

Skin clips should never be used for closing wounds of the face. They should not be used for temporary closure. Suture materials of a large gauge should not be used, such as heavy catgut and silkworm gut. Dermal suture is well tolerated and has good tensile strength. Dermal sutures are made of long fiber strands of twisted silk impregnated with a special gum to give them strength, smoothness and non-capillarity. Certain sutures—for example, plain silk and linen—are capillary, so that fluid, perhaps carrying bacteria, can travel along them to internal tissue. Horse hair is fine and has little tensile strength, but used in the skin surface is adequate to maintain approximation of skin edges. Needles should be of fine gauge, such as those used by the eye surgeon. Skin-hooks should be used to hold the skin edges while suturing instead of forceps. The latter may pinch the tissue, causing necrosis.

The technic of suturing is more complicated than simply placing interrupted sutures. These can only be allowed to remain a short time in order to avoid "stitch



Fig. 8. (left) This boy was cut by broken glass from a headlight of a truck which struck him. His general condition necessitated a rapid closure of the wounds.

Fig. 9. (right) The wounds were closed with interrupted subcuticular dermal and interrupted horse-hair sutures tied only once to eliminate knot pressure scars.

second layer of sutures is a continuous thread of fine dermal. This is placed in the dermis, beginning away from the wound and entering it at the proper level. The dermal suture is laced back and forth through the length of the wound and makes its exit just as it entered (Fig. 7). The third (superficial) layer of sutures is horse hair. This is placed in the same way as the second (dermal) layer, but in the epidermis (Fig. 7). Extreme care must be taken in



placing this layer of sutures in order to obtain as nearly microscopical approximation of the wound edges as possible. Occasionally, a few interrupted horsehair sutures are required to obtain accurate opposition at the

with a small instrument. This is very tedious work but the patient will be grateful.

Pressure bandages may be applied over wounds that have been extensively undermined. Pressure bandages may consist of



Fig. 10. (a) This patient was thrown forward against the instrument panel of an automobile. The laceration of his scalp and forehead exposed his skull bone and a flap was raised medially. The laceration along the side of his nose exposed the nasal septum. (b) The wounds were closed with three layers of sutures. A few interrupted horse-hair sutures tied only once were placed to accurately approximate the epidermis. (c) The results after healing had taken place. No "stitch-marks" are present.



Fig. 11. (a) The patient was riding in the rear seat of an automobile. The driver applied the brakes suddenly and she was thrown forward against the edge of the robe rail. (b) The laceration extended through the lateral nasal wall and septum and into the inner canthus of her left eye. There was an entire section of her left upper eyelid severed. (c) Results obtained by carefully closing the wounds, placing sutures below the surface after the edges were freshened and made regular.

surface. These should be tied only once to avoid knot pressure scars (Figs. 8, 9, 10-a, b, c, and 11-a, b, c).

When there is a loss of an area of skin too large to close by suturing, a full thickness graft may be employed to cover the defect immediately. The full thickness graft may be taken from behind the ear, or the inner surface of the arm. The skin in these regions is of fine texture and non-hair bearing and matches the facial skin closely, especially the post-auricular.

"Brush burns" should be thoroughly scrubbed with tincture of green soap and a stiff brush (Figs. 12-a, b, c, and 13). The ground in foreign bodies, such as minute particles of gravel and stone which are embedded in the skin, must be removed

gauze or sea sponge held in place by roll bandage or adhesive strapping. When a pressure bandage is not needed, collodion-gauze dressing may be used over the wounds. Fine mesh roll bandage cut in sections to cover the wounds are held with collodion. They may be readily removed with acetone solution. Applications of these collodion dressings should be continued for three weeks to reinforce the healing wound and avoid wide scars. Cotton should never be placed over wounds directly, because such a dressing results in matting and favors supuration.

The optimum temperature for wound healing is body temperature. Therefore, avoid the necessity for ice bags to promote hemostasis.

The use of fine suture material and early removal of sutures should be kept in mind to avoid "stitch marks." Superficial horse hair as so designated in this paper, and in-

if the patient has a brain or skull injury. The choice of method of immobilization of the jaws depends on the individual case. Inter-maxillary wiring is the simplest and



Fig. 12. (a) This patient was struck by an automobile and dragged underneath it. A large flap of scalp tissue was evulsed exposing the skull bones. The laceration extended to just below the outer canthus of the right eye. There were "brush-burns" over the entire right side of her face and neck. (b) and (c) The result obtained is shown. The scalp and face wound was filled with hair, broken glass and street dirt. This was carefully removed mechanically and the wound was washed with saline. The wound edges were freshened and made regular. The flap was replaced and the wound closed with three layers of sutures. A pressure bandage was applied. The "brush-burns" were thoroughly scrubbed with a stiff brush and tincture of green soap. The denuded areas were covered with gauze impregnated with oxyquinalin scarlet-red ointment.

errupted horse hair, should be removed in 36 to 48 hours. The inter-cuticular dermal may be allowed to remain seven days or longer.

Facial wounds are all potentially infected. The bacterial invasion is rapid even in the absence of foreign bodies. They may gain their entrance through the broken skin, or through the nasal and oral cavities, if there is communication. Fine flat rubber drains should be inserted into wounds which have been allowed to remain open for twelve hours or more. Deep wounds that expose bone or which communicate with a fractured bone should have drainage established.

If treatment is not instituted for 24 hours, it is better to cover the wound with hot sterile packs for a few hours and close the wound later to minimize secondary scar formation.

The location and direction of the laceration and infection are important factors in minimal scar formation. The tendency to keloid formation in certain people cannot be controlled. It is not infrequent that patients need secondary operations for the removal of scars.

Fractures of facial bones should be reduced as early as the patient's condition will allow. Too early manipulation is harmful



Fig. 13. This boy was struck by an automobile and dragged for several feet. His face, especially the left side, was "brush-burned." Due to his condition the wounds were allowed to heal without treatment and there resulted the "tattoo" carbon scars shown in the dark areas. (Compare with Figure 12.)

most effective method. Dental plates may be used as splints in edentulous cases.

Depressed malar bones may be raised by one of several ways, but through an oral approach a facial scar can be avoided.

Fractured nasal bones should be molded into position and held by internal or external pressure. The septum, if injured, should be straightened as well as possible.



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## FRACTURE OF THE NECK OF THE FEMUR\*

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Fracture of the neck of the femur has always been recognized as a most difficult fracture to treat. To the difficulty many factors contribute. Of these the most important can be placed in three classifications, constitutional, anatomical and mechanical.

The constitutional factors arise from the fact that most victims of fractures of the neck of the femur are elderly people, to whom any accident is a serious matter. Their vital forces are at a low ebb, and their circulations are poor, so that pneumonia, digestive disturbances, and exhaustion are apt to follow any treatment which involves long confinement in bed.

The anatomical factors arise, first, from the arrangement of the blood supply of the neck. In its outer or trochanteric portion the neck is well supplied with blood from the nutrient arteries and from the periosteum, but in its inner or intracapsular portion the blood supply comes principally from the neck, whose blood vessels cross the epiphyseal line, to vessels which enter the head along the edge of the articular surface close to the epiphyseal line, from a possible periosteal source within the capsule (Kolodny) and rarely, in elderly people, the ligamentum teres. The hip capsule is the source of some of these vessels. Fracture through the neck must always tear the capsule to a greater or less extent, thereby cutting off some of the blood from the proximal fragment and head, and all the blood which comes from the trochanteric region. The remaining epiphyseal supply is poor. Thus the blood supply to the proximal fragment must be inadequate after any fracture of the neck, and its bone-forming powers are therefore slight. This fact in itself is enough to account for the slow healing which always occurs, and the nonunion, which often occurs in fractures of the neck even with best of treatment. The better blood supply accounts for the fact that fractures in the tro-

chanteric region must always unite promptly, even under indifferent treatment.

If a fracture of the neck is not accurately reduced there is little or no chance for the head to acquire a good blood supply.

If the reduction is good, then there is the probability of new vessel formation from the trochanteric region across the line of fracture.

Another anatomical factor arises from the fact that there are no ligamentous or muscular attachments to the head. The head therefore cannot be controlled or manipulated. The distal fragment must be brought into line with it.

The mechanical factors arise principally from the fact that the fracture is so deeply placed that no direct manual control of it is possible and efficient retentive apparatus is hard to construct. Even a double plaster spica is insecure in heavy patients.

The older methods of treatment, such as sandbag fixation in bed, simple splints, and traction, were unsatisfactory. Although occasional patients got good bone union, fibrous union and permanently unstable hips were the rule. The search for better methods began long ago and many forms of treatment have been devised. They are of two general types, those which employ closed reduction with some method of external fixation, and those which employ

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either open or closed reduction with some form of internal fixation. It is worthwhile to review some of these. In 1918 R. Whitman<sup>14</sup> of New York published his method of closed reduction. It was the most carefully reasoned scheme up to that time. It consisted essentially of manipulation under a general anesthetic in which traction brought the outer fragment down to its normal level, and restored the normal angle of the neck and then forcible internal rotation and wide abduction brought the fractured surfaces into accurate contact and locked them there. Both legs and the pelvis were then placed in a well fitted plaster spica, which was left in place for three to six months. The method depends for its success on the use it makes of the Y ligament of Bigelow, which is usually intact, to pull the proximal fragment into alignment with the distal. This method was adopted almost universally. In 1933 Leadbetter<sup>6</sup> modified the Whitman method by applying the tractive effort and the internal rotation while the hip was flexed at a right angle. This was an improvement, as it made reduction less difficult. These two methods have now generally replaced all other methods of closed treatment. By their use a fracture of the neck of the femur can be reduced satisfactorily and the reduction maintained. Both methods require long confinement to bed. Kleinberg<sup>5</sup> has recently overcome this objection by getting the patients treated by this method up on crutches in their plaster spicas, and allowing them to bear weight on the injured hip.

Unfortunately, no matter how perfect the reduction may seem to be, bony union does not always follow. In fact, failure to unite is discouragingly frequent. A committee of the American Orthopedic Association, two years ago, reported after a country-wide investigation, that in well recognized clinics the percentage of failure ran as high as fifty. Only 50 per cent got good union by the closed methods. Dr. Whitman's clinics in New York report a much higher percentage of success, probably due to more intimate acquaintance with the method.

The poor results of conservative treatment of this fracture long ago led to attempts to improve them by means of open operation and internal fixation. Most of these, until recently, were directed toward the amelioration of the sufferings of pa-

tients whose fractured hips had failed to unite after many months of treatment. As long ago as 1858 Von Haugenbeck<sup>12</sup> did an open reduction and fixation of an ununited fracture by means of a screw. Death resulted. Loretta,<sup>7</sup> in 1888, attempted to wire an ununited fracture. Although the wiring failed, the fracture healed. Mueller,<sup>9</sup> in 1896, cured a long standing case of non-union by inserting a drill obliquely through the trochanter and head, using an anterior wound. Willy Myer,<sup>10</sup> in 1893, used nails. Sayre, in 1898, used a gimlet. I myself helped nail an ununited fracture in 1904 through a small trochanteric incision, using a four inch ordinary iron spike. Not until Albee reported his method in Murphy's "Clinic," June, 1913, was surgical interferences in these fractures put on a sound basis. His method consisted of open reduction through an anterior incision, followed by a second incision over the trochanter. Through this latter incision a drill was passed obliquely upward through the trochanter into the head, its course being guided by observation, through the anterior incision. A dowel was then made from a tibial graft which exactly fitted the drill hole. This was firmly driven home, the wound closed and a plaster-of-Paris spica applied. Albee correctly claimed for his method accuracy of reduction, solidity of fixation, on physiological principles, no foreign bodies, and stimulation of bone repair by the graft. The objections to his method, which have gradually forced it into disuse, are the magnitude of the two operations involved, the difficulty of accurate placing of the drill and accurate fitting of the graft and the fact that the graft sometimes broke and nonunion resulted. To my mind the operation still holds a place for the treatment of ununited fractures in patients who are good surgical risks. This operation was not primarily intended for use in fresh fractures, but it set men thinking in terms of accurate surgery in regard to fresh hip fractures.

The modern popularity of surgical treatment may be said to have begun when Smith-Peterson<sup>11</sup> published his article on the successful results in twenty-four cases of fresh fractures operated upon between 1925 and 1930 by his open reduction method, after which he used a three flanged nail, placed under visual guidance, through the trochanter and neck, for fixation. Smith-



Peterson used the three flanged nail because it could be made very strong with a thin cross section which did not split bone, and because it had a large area for frictional grip on the cancellous bone of the neck and head. Smith-Peterson's method was greeted with keen interest, but some doubt, this latter principally directed at the severity of the double operation, and the use of a foreign body. The fundamental value of the principles of the Smith-Peterson procedure was promptly recognized and a host of men rushed into the field with operations designed to correct the faults or improve on the advantages of the operation. Johannsen<sup>3</sup> of Sweden used a nail which is perforated to fit over a guide wire previously inserted in the proper position in the trochanter and head. Westcott<sup>13</sup> of Virginia first suggested that the open reduction of the Smith-Peterson procedure be replaced by closed reduction and nailing through a single trochanteric incision under the guidance of repeated x-rays. King<sup>4</sup> of Australia used a cannulated nail with two wire guides under fluoroscopic control. Gaenslen,<sup>1</sup> in 1935, suggested that heavy wire spikes be substituted for the nail and that five or six of them be driven subcutaneously at slightly different angles. His idea was to avoid the necessity of any open incision. Moore,<sup>8</sup> in 1936, suggested three heavy wire nails driven at different angles. These nails have screwheads on which lock nuts are placed. These nuts are for two purposes: first, to hold the trochanter from backing away from the head, and, second, to prevent the nails from working inward and entering the pelvis. Henderson<sup>2</sup> has just reported the use of a lag screw. These and many other slightly different schemes have been used with success. In spite of them nonunion still occurs occasionally.

Most of these methods of internal fixation have been in use long enough to permit evaluation of their advantages and disadvantages in the treatment of fresh fractures. All reports of series of cases treated by internal fixation show a much better percentage of bony union than do those treated without operation. Some of them give one hundred per cent of success. The immediate mortality of the operative procedure was higher than the closed methods until open reduction of the fracture was abandoned in favor of the so-called "blind nailing."

Since then it has been lower because immediate physical activity is allowable and confinement to bed is short. After the non-operative treatment fixation of the knee and hip for long periods was necessary. After internal fixation this period of fixation is short, and sometimes absent. Thus by the time the patient whose hip has been nailed has sufficient union to justify weight bearing, the knee and hip are movable and the muscles are in good condition. There is no comparison between the comfort of the two methods to the patient. The elderly person in a double plaster-of-Paris spica is uncomfortable, to put it mildly. The nailed patient needs no such plaster, and is free to move about in bed from the first. He is infinitely easier, therefore, to nurse. The nailed patient can be gotten up in a wheel chair in a month and on crutches within eight weeks. Weight bearing on the nail, if it is properly placed, even though bony union is not complete, may be allowed at this time.

For all these reasons I am persuaded that some form of internal fixation is the best for fresh fracture of the neck of the femur. Personally I prefer the Smith-Peterson nail, as modified by White, driven through a trochanteric incision. I use a guide wire and repeated x-ray control. Gas-oxygen, avertin or local anesthesia may be used. The operation should be done as soon as the patient has recovered from shock and before pneumonia or intestinal stasis has time to develop. To my mind the operation is technically very difficult and should not be attempted except under the most favorable surroundings, where skilled help, first class x-ray equipment, personal and perfect operating room technic are at hand. If such conditions are not obtainable the Whitman or Leadbetter method of closed reduction should be used.

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## PRIMARY CARCINOMA OF THE JEJUNUM

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Primary carcinoma of the jejunum is not only an infrequent lesion, but an interesting one as well, because of the difficulty in making an early diagnosis, the irregularity of the symptoms, and the unusual response to surgical treatment.

Although the jejunum is the most frequent site for carcinoma of the small intestine, the incidence is only 0.15 per cent of all gastro-intestinal carcinomas, according to the most recent survey by Mayo and Nettrour.

We wish to add two cases to the existing small list of reported cases, and, in doing so, compare the symptoms presented in our cases, each differing widely in symptomatology, with the usual symptoms of the cases reviewed in the literature on this condition.

Epigastric distress is the most common symptom of this disease, and may vary in intensity from real severe to dull pain, cramps or discomfort. One of our cases had dull, gnawing pains off and on for seven months, and constant pain for two weeks prior to admission to the hospital. The other case was free from pain.

Anemia is quite constant in most of the reported cases, and many writers have advised suspecting carcinoma of the small bowel in all cases of unexplained anemia. Plunkett, Foley and Snell have explained that the anemia may result from both the occult bleeding and the interference with the absorptive function of the small intestine. The presence of occult blood in the stool with anemia should always lead one to suspect intestinal malignancy. Anemia was the outstanding symptom in one of our cases, and he had been under treatment for this condition with iron and liver extract for six months prior to admission to the hospital. The other case showed a slight degree of anemia in his blood count, but no apparent anemia in his general appearance.

Loss of weight is usually present, and it occurred in both of our cases, one having lost forty pounds in a year, and the other twelve pounds in four weeks. Heartburn, indigestion, nausea and vomiting are variable symptoms, and were present in only one of our cases. There was no loss of appetite in either case.

Many cases have constipation or diarrhea, and increasing constipation was an outstanding symptom in one of our patients,

while the other had regular normal stools.

A tumor mass in the upper abdomen is usually a late finding in this disease, and was present in one of our cases.

Roentgenological examination was carried out in our first case and showed a definite obstruction of the jejunum about eighteen inches from the pylorus. In the second individual, an incomplete roentgenological examination was done seven months prior to admission to the hospital, with negative results, and, as a large tumor mass in the upper abdomen was discovered shortly before operation, we deemed an x-ray inadvisable.

The first case presented a small annular lesion, the second a large tumor mass. Both were advanced adenocarcinoma; in the first there were small glandular metastases and none were present in the second. In the first case a resection and an end-to-end anastomosis was performed, and in the second a resection and a lateral anastomosis was done on account of the edema in the wall of the adjacent small bowel. Enterostomy was performed distal to the anastomosis in both instances.

Both patients made uneventful recoveries and are alive, well, and apparently in good physical condition, twenty-eight and eighteen months, respectively, after operation.

*Case 1.*—W. G., a white man, aged fifty-seven, whose occupation was office clerk, was admitted to Harper Hospital February 6, 1936, when he complained of indigestion, heartburn and eructations of gas for one year, and nausea and vomiting for one week. He never had any abdominal pain or soreness. His appetite was always good, and even during the past week, when he had had considerable nausea and vomiting after eating.

He had lost about twelve pounds in the last four weeks. The bowels were always regular, and the stools were normal in appearance.



His family and past history were negative. He had had good health until the present illness.

Physical examination revealed a well nourished white male, not acutely ill, but somewhat dehydrated. The blood pressure was 140/80. The only

Postoperative treatment consisted of reattaching the Levine tube, which was left in during the operation, to a suction apparatus. Subcutaneous and intravenous fluids were freely given. Mouth hygiene was watched and the patient was given fruit candies



Fig. 1. Case 1. Radiograph showing dilatation of the jejunum proximal to growth.

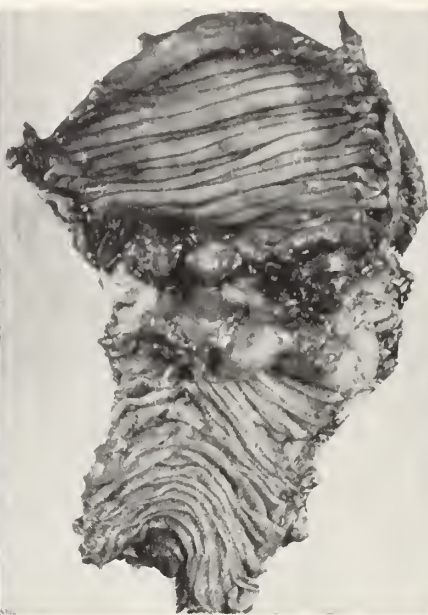


Fig. 2. Case 1.

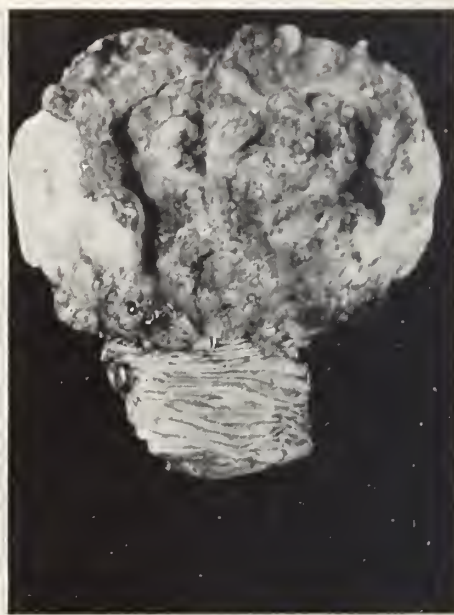


Fig. 3. Case 2.

positive finding was moderate upper abdominal distention and tympany. There was no abdominal tenderness.

Laboratory findings: Urinalysis—slight trace of sugar. Blood count: Hemoglobin 79 per cent, erythrocytes 4,970,000, leukocytes 9,200, polymorphonuclears 71 per cent, large lymphocytes 26 per cent, mononuclears 2 per cent, basophiles 1 per cent. Kahn test negative. Blood nitrogen 34.2 mmgs. Blood chlorides 495 mmgs.

Roentgenological examination with the barium meal showed a large stomach with practically total retention at four hours, and marked retention at twenty-four hours. Marked dilatation of the proximal jejunal loop with obstruction of the jejunum about eighteen inches from the pylorus.

A Levine tube was passed and attached to a suction apparatus. The patient was given clear fluids freely by mouth and glucose in saline solution intravenously.

Operation was performed February 11, 1936, by means of 150 mgms. novocaine spinal anesthesia. A five-inch left paramedian incision was made. No free fluid was found in the abdominal cavity. The liver was normal. The gall bladder was distended, but no stones were palpated.

The stomach was slightly dilated. The duodenum felt normal. There was an annular obstructing lesion in the jejunum about 7 inches from the duodeno-jejunal junction. No glands were felt. A resection was done with a wedge-shaped resection of the mesentery, and an end-to-end anastomosis performed. Distal Witzel type enterostomy was then done and the wound closed in the usual manner. A prophylactic dose of tetanus-gas gangrene serum was given.

Pathological examination.—Gross: A moderately indurated circular fungating mass involving the entire wall of small bowel was found. Serosa border had been ulcerated through and was constricted. Microscopical: Advanced adenocarcinoma. Metastatic in adjacent lymph node.

to suck. Clear fluids were given by mouth on the second day. Saline and glucose solution was inserted into the enterostomy tube every two hours. The Levine tube was removed on the fifth day and a light soft diet was given. The instillations into the enterostomy tube were discontinued on the sixth day, and the tube came out spontaneously on the tenth day. The patient was sitting up in bed on the tenth day, was up in a chair on the twelfth, and was walking on the fourteenth day. The wound healed by primary union and the patient was discharged from the hospital on the sixteenth post-operative day.

The patient gained 10 pounds in weight during the month after leaving the hospital. He has been in perfect health since and is being kept under observation.

Case 2.—F. N., a white man, aged sixty-five, occupation—painter, was admitted to Harper Hospital when he complained of increasing weakness, loss of forty pounds in weight and increasing constipation for the past year; dull, gnawing pain in the upper abdomen for seven months, constant for the prior two weeks. His appetite had been good, but lately he had a feeling of fullness after eating. He had been taking iron tonic and getting hypos of liver extract for the last seven months. He has had frequency of urination day and night for the past three months.

The family and past history are negative. He had always been in good health except for one attack of influenza years ago. He did not use tobacco or alcohol.

Physical examination revealed a well developed white male, not acutely ill, but showing definite signs of emaciation and anemia. The blood pressure was 118/76. The only positive findings were a slight systolic heart murmur, a few fine crepitant râles over the bases of both lungs, a large soft prostate, and a large round, smooth, tender movable mass just to the right of the umbilicus.

Laboratory findings: Urinalysis was negative.



Blood count: hemoglobin 55 per cent; erythrocytes 4,020,000; leukocytes 12,100; polymorphonuclears 70 per cent, lymphocytes 20 per cent, eosinophiles 9 per cent, basophile 1 per cent. Blood sugar .125 per cent. Blood nitrogen 27 mmg. Blood chlorides 495 mmg. Blood Kahn test was negative. Electrocardiograph showed early coronary sclerosis but no notable myocardial changes.

The patient was prepared for an exploratory operation with intravenous glucose and saline.

Operation was performed two days later under ether anesthesia. A high right rectus incision was made; no free fluid was found in the abdominal cavity. The stomach, gall bladder, spleen, pancreas, duodenum and colon were normal. The liver showed moderate hepatitis, but there was no evidence of metastases. A large mass the size of a grapefruit was then exposed, and found to involve the jejunum about 12 inches from the ligament of Treitz. The mass was freely movable, and there were a few enlarged mesenteric glands. The jejunum proximal and distal to the growth showed considerable edema, so it was deemed advisable to resect the growth, including the mesenteric glands, and to close both ends of the bowel and perform a lateral anastomosis. These procedures were carried out. An enterostomy was then performed distal to the anastomosis, and the wound was closed in the usual manner.

A continuous drip cannula was inserted into the vein of the arm, and the patient was given 500 c.c. of blood during the operation, the cannula being left intact for venoclysis. A prophylactic dose of tetanus-gas gangrene serum was given.

Pathological examination.—Gross description: Specimen measured 23 x 20 x 18 cms. The specimen had been cut in the long axis of the bowel; both proximal and distal portions of the bowel were normal. Between the normal bowel there was an irregular, firm, cauliflower-like mass which practically obliterated the lumen. On the cut surface the tumor mass presented an opaque, white, firm nodular mass of tissue in which are scattered several small, yellowish-white nodules with some degenerative changes in the center. In several areas there are collections of a hemorrhagic exudate which covers the margins near the normal bowel. There are several small glands in the attached mesentery. Microscopic diagnosis: Advanced adenocarcinoma—not metastatic in the lymph nodes.

Postoperative treatment consisted of continuous venoclysis of 10 per cent glucose in saline at the rate of forty drops per minute for five days. The cannula was then removed and 1,000 c.c. of solution was given intravenously daily for seven days. A Levine tube was inserted and attached to a suction apparatus and it was clamped part time on the fifth day and was removed on the eighth day. An indwelling catheter was inserted into the bladder and removed on the thirteenth day. Glucose and saline

solution was instilled into the enterostomy tube every two hours, the tube coming out spontaneously on the eighth day. Fluids were given on the second day and a high caloric soft diet on the eighth day, with the addition of ferric ammonium citrate 45 grains daily. Two hundred c.c. of blood were given the fourth, and 150 c.c. on the fifth day after the operation. The wound healed well, and the patient was up in a chair on the fourteenth day and discharged from the hospital on the seventeenth post-operative day. The patient gained 20 pounds of weight in two months. His blood count February, 1937, was, hemoglobin 85 per cent, erythrocytes 4,780,000. Roentgenological examination February fifteenth showed the barium meal to pass through the jejunum at a normal rate. He resumed his occupation, regained his lost weight, and has been in perfect health since.

### Summary

1. Two interesting cases of primary carcinoma of the jejunum are reported.
2. Both cases presented a different group of symptoms and differed in many details.
3. Both cases made uneventful recoveries after operation, and are in good health twenty-eight and eighteen months, respectively, after operation.

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## THE USE OF DRIED BILE AS A THERAPEUTIC AGENT\*

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The rôle of bile in digestion is an important one. When bile is drained continuously for a long period the subject becomes thin and emaciated, even though fluids and inorganic salts are given in ample quantities. That this is due to lack of normal bile in the intestinal tract sufficient to carry out normal digestive processes is suggested by the fact that a similar picture is seen in cases of long standing obstruction of the common bile duct. For a considerable number of years bile obtained from choledochostomy drainage has been fed back into the patient by mouth. A beneficial effect was noted although it was appreciated that the bile draining from a recently decompressed liver often was deficient in quality.

Because of this recognized deficiency, C. G. Johnston, while associated with I. S. Ravdin of the University of Pennsylvania in 1935, replaced the bile lost from patients through drainage by substituting liquid animal bile.<sup>5</sup> Considerable difficulty and inconvenience was encountered in the collection and preservation of the bile. In addition, liquid bile is most distasteful, although this can be overcome by feeding the bile through a stomach tube. The usual dried bile preparations available were found to be inadequate.

In an attempt to prepare bile in dried form from which the original sample of bile could be reproduced by the addition of water, the method of drying described by Flosdorf and Mudd<sup>3</sup> for the lyophilization of serum was used. By this procedure it is possible to remove from beef, pig or human bile most of the water, and a dry yellow powder results. When water is added to this material it readily forms a solution not unlike the bile from which it is prepared. The method used by Flosdorf and Mudd was not suitable for quantity production and the resulting preparation was sticky and not easily handled. Through the courtesy of Parke, Davis and Company we have since had prepared a much more suitable product by the process of vacuum distillation routinely used for drying biological and other materials. The process consists of drying bile in high vacuum, the vacuum distillation cooling the system sufficiently so that the use of dry ice as used by Flosdorf and Mudd is found unnecessary. Pig bile so prepared results in a dry, fluffy,

golden material which readily dissolves to form liquid bile physically resembling the original specimen. Approximately 9 c.c. of pig gallbladder bile is necessary to prepare one gram of dried substance.

The symptoms associated with lack of bile in the gastro-intestinal tract are lack of strength, anorexia, distention, constipation and malaise. The gastric and intestinal motility and tone are decreased, the stools become clay colored and greasy and loss of weight is quite common. In those cases where there is complete absence of bile from the gastro-intestinal tract these symptoms are usually quite constant and clear-cut. Many individuals who have no frank evidence of lack of bile in the intestinal tract suffer from a similar train of symptoms, less severe and less definite but closely akin, which the laity calls "biliousness." Unquestionably, many such attacks have nothing to do with biliary diseases, and in this group of cases it is often difficult to determine definite etiological factors. Such episodes are frequently associated with flatulence, loss of appetite, slight distention and constipation.

Carlson and Still<sup>11</sup> demonstrated that, associated with the absence of bile from the intestinal tract, hunger contractions are decreased, as is gastric motility. This forms a basis for the explanation of the anorexia associated with the absence of bile in the intestinal tract and possibly also for the constipation and distention. We have found that even in normal animals the ingestion of the dried bile preparation increases the gastric tone and the amplitude and rate of gastric contractions.

It is probably not necessary for the bile in the intestinal tract to be decreased in amount to produce symptoms; a qualitative

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deficiency might result in a similar train of symptoms. Following release of obstruction of the common duct, bile is known to be deficient in at least one constituent, namely bile salts.<sup>1,8,9</sup> It is quite likely that associated with varying degrees of hepatic insufficiency, variations in the composition of the bile occur.

The use of whole bile in cases where bile is totally or partially excluded from the intestinal tract, as in the case of drainage of the common duct, is now a well established procedure and is based on sound and fundamental considerations. Dried bile properly prepared has proven satisfactory as a substitute for whole bile and has been used for the past few years on the service of Dr. I. S. Ravdin at the Hospital of the University of Pennsylvania and on the service of Dr. Charles G. Johnston at Receiving Hospital in Detroit. In this report we shall limit our discussion to the use of dried bile in cases where there is no loss of bile through drainage, but in which there are symptoms which might be attributable to the deficiency in the quantity or quality of bile in the intestinal tract. The chief symptom for which the dried bile has been given is loss of appetite. It is not to be expected that dried bile will relieve this symptom in all cases. Increase in motility of the stomach need not in itself affect anorexia; in fact, it is quite possible that in some cases one might expect an aggravation of this symptom. In our experience this has been true, especially where it was tried on a purely empirical basis.

Our best results have been obtained in those cases where there has been definite evidence of biliary disease. Where bile feeding has proven efficacious the increase in appetite has been evident usually within a few hours. In an occasional instance, however, anorexia has been increased even though the underlying factor has been a definite biliary disorder. We are presenting a few typical case reports to illustrate the effects of bile therapy.

*Case 1.*—A white woman, twenty-five years of age, had a cholecystectomy performed in February, 1937, at which time a gallbladder filled with stones was removed. She had had numerous attacks of jaundice, fever, and upper right quadrant pain. From February, 1937, until admission to the hospital, March 21, 1938, she complained of daily chills and fever, severe right upper quadrant pain, nausea and vomiting. Physical examination revealed a slender, young white woman definitely jaundiced. Her temperature was 105 degrees. There was

marked spasm of the right upper rectus muscle and tenderness in the right upper hypochondrium. The patient was given transfusions and intravenous glucose solutions. She was put on a high carbohydrate diet but was unable to eat satisfactorily because of marked anorexia. She was given two capsules of pig bile (0.35 gm. each) three times a day with meals. Her anorexia ceased after the first bile feeding and her appetite remained excellent during her preoperative period.

*Case 2.*—A white girl, ten years of age, was admitted to the hospital complaining of abdominal pain, anorexia, nausea, vomiting, jaundice, and chilly sensations. She also was constipated. The above symptoms had been present for one week. Physical examination revealed a rather thin, jaundiced girl whose essential physical findings were in the abdomen, consisting of mild right sided subcostal tenderness. Her temperature was 99.3 degrees, the urine negative, and complete blood count normal. A diagnosis of acute catarrhal jaundice was made. Transfusions and intravenous glucose solutions were given. Two capsules of pig bile (0.35 gm. each) were given three times daily. The anorexia immediately subsided and the patient began to eat normally. Within three weeks she gained eight pounds in weight.

*Case 3.*—A white man, sixty-five years of age, had been suffering with anorexia, weakness, loss of weight and enlargement of abdomen with recurrent jaundice for the past five years. Two years ago, he was completely studied at a large Chicago clinic, at which time a diagnosis of cirrhosis of liver was made. Since that time he has had marked anorexia, gaseous distention, belching and constipation. Dry pig bile (1 gram 4 times a day) was administered and after one day the above symptoms disappeared. He stated that this was the first time in five years that he really had enjoyed his meals. This relief of symptoms continued.

Table I lists the results obtained in twenty-seven cases. These constitute our best results, and in the majority definite improvement followed the bile feeding. We also have used this preparation in a large number of cases in which there was, as far as we could determine, no relationship between the symptoms and the production and excretion of bile, but in which there was anorexia. The majority of these latter cases either showed no beneficial effects from bile feeding or only slight improvement, and in some instances the anorexia was actually increased.

### Comment

For many years bile preparations have been used to alleviate symptoms occurring in gastro-intestinal disorders. Most of the bile preparations have not been effective and none of these preparations with which we are familiar are capable of dissolving to form bile. As may be seen by the foregoing report, in suitable cases feeding of dried bile has been effective in the relief of anorexia. Also the associated symptoms of



# DRIED BILE AS A THERAPEUTIC AGENT—WINFIELD

TABLE I. RESULTS OBTAINED IN TWENTY-SEVEN CASES

Color Sex	Age	Diagnosis	Jaundice	Anorexia	Distention Belching	Constipation	Dosage	Results
W F	G.C. 10	Acute Catarrhal jaundice	++	Marked	Moderate	Moderate	Caps ii	Immediate relief. Seen in follow-up one month later. Symptoms gone and gaining weight.
C F	I.C. 36	Carcinoma of cecum	—	Marked	Marked	Moderate	Caps ii t.i.d.	Appetite definitely improved and began to gain wt. preop. Right colon resected.
W F	G.K. 34	Adhesions gallbladder area	—	Marked	Marked	Moderate	Caps ii t.i.d.	Appetite improved after giving of bile.
W F	P.K. 30	Chronic Calculus. Cholecystitis. Lues	—	P.O. Marked	—	—	Caps ii q.i.d.	Had cholecystectomy and given caps q.i.d. with marked improvement. Stopped for 3 days, appetite decreased so started again
W F	P.H. 52	Portal and biliary cirrhosis. Secondary anemia	++	Marked	Marked	Moderate	Caps ii t.i.d.	Patient in poor condition. Appetite improved for 24 hrs., but patient went steadily downhill and died.
C M	G.E. 21	Acute catarrhal jaundice	++	Marked	Moderate	Moderate	Caps ii q.i.d.	Appetite responded rapidly but general condition was improving at same time.
C M	J.R. 76	Carcinoma of head of pancreas. Carcinomatosis	+	Marked	Moderate	Moderate	Caps ii t.i.d.	Patient had downhill course. Refused operation. Bile caps relieved anorexia but patient expired.
W M	G.S. 54	Carcinoma of head of pancreas. Duodenal diverticulum	++	Marked	Marked	Moderate	Caps iii q.i.d.	Appetite improved slightly.
C M	B.C. 31	Pneumonia	—	Mild	Mild	Mild	Caps iii t.i.d.	Appetite improved.
W M	C.B. 43	Acute yellow atrophy, toxic hepatitis.	++	Mild	Marked	Moderate	Caps ii q.i.d.	Improved appetite temporarily but patient developed acute yellow atrophy and died.
W F	M.A. 26	Obstructive jaundice	++	Marked	Mild	Marked	Caps ii t.i.d.	Immediate relief of anorexia.
W F	P.H. 30	P.O. Cholecystectomy	—	Occasional	Mild	—	Caps t.i.d.	No relief after taking caps t.i.d. for 1 month.
W M	G.L. 46	Catarrhal jaundice. Gastric ulcer	++	Marked	Marked	Moderate	Caps ii t.i.d.	Appetite immediately improved. Continued 1 month and symptoms gone.
W F	W.N. 38	Interstitial hepatitis.	Sub-icteric	Marked	Mild	Mild	Caps ii t.i.d.	Showed slight improvement. Reduction in gas and increase in appetite after 2 wks. feeding of bile. Improvement in general condition.

## DRIED BILE AS A THERAPEUTIC AGENT—WINFIELD

TABLE I. RESULTS OBTAINED IN TWENTY-SEVEN CASES—*Continued*

Color Sex	Age	Diagnosis	Jaundice	Anorexia	Distention Belching	Constipation	Dosage	Results
W F	S. 60	Obstruction common duct	++	Marked	Marked	Moderate	Caps ii t.i.d.	Marked improvement in appetite. Reduction of gas.
W M	J.S. 60	Acute cholecystitis.	+	Mild	Mild	Mild	Caps ii t.i.d.	Showed slight improvement when symptoms subsided. (Bile in urine decreased and icteric index down.)
W F	S.K. 42	Postoperative cholecystostomy.	+ subsid-ing	Mild	Moderate	Moderate	Caps ii t.i.d.	Definite improvement in appetite
W F	A.W. 65	"Gallbladder trouble" for years. Dyspepsia.	-	Unable to eat fats	Marked	Moderate	Caps ii q.i.d.	After 1 week, gas improved and patient felt better. More appetite. Stopped bile.
W M	M.S. 29	Unable to gain weight	-	"Poor appetite"	-	-	Caps ii q.i.d.	Appetite improved rapidly. Laxative effect. Gained 3 lbs. in one week.
W M	S 65	Cirrhosis of liver	Sub-clinical	Marked	Marked	Moderate	Caps ii q.i.d.	Immediate relief of all symptoms and increase in appetite.
W M	C.W. 36	Common duct obstruction	++	Marked	Marked	Marked	Caps iii q.i.d.	Appetite improved. Gas and constipation relieved.
W F	W.S. 40	Acute gallbladder. Common duct obstruction and hepatitis	+	Marked	Marked	Moderate	Caps ii q.i.d.	Appetite improved in 1 day and other symptoms subsided.
W M	R.A. 31	Catarrhal jaundice. Post-infectious	++	Marked	Marked	Marked	Caps ii q.i.d.	Patient was desperately ill. An improvement in appetite occurred faster than would be expected in so sick a patient even though convalescence was progressing favorably.
W M	H.A. 65	Diabetes Hepatitis	+	Moderate	Moderate	Mild	Caps iii t.i.d.	Patient received bile feeding for 2 wks. and showed no improvement.
B M	B.C. 31	Cirrhosis of liver	sub-clinical	Moderate	Mild	None	Caps iii t.i.d.	Results indeterminate Appetite varied. Bile feedings discontinued after four days.
B F	L.G. 31	Common duct obstruction	++	Marked	Moderate	Mild	Caps ii q.i.d.	Bile feedings for 1 wk. No improvement. Stopped as nausea increased.
W M	W.R. 54	Cholecystectomy 8 yrs. ago. ? Acute pancreatitis	+	Marked	Moderate	Moderate	Caps ii q.i.d.	After 4 days of bile feeding patient showed slight improvement only.



belching, distention and constipation have been materially affected in the majority of cases. It has also been noted that dried bile has a slightly laxative effect. Since the preparation of dried bile which we use is soluble, it is suitable for use in a variety of conditions. The recent work by Greaves and Schmidt,<sup>4</sup> Osterberg, Butt and Snell,<sup>2</sup> and Quick,<sup>7</sup> who noted the effect of vitamin K on the reduction of prothrombin time in jaundiced patients, emphasized the importance of the use of bile in connection with this vitamin. The use of the dried bile forms a simple means of supplying additional bile so necessary for the absorption of vitamin K.

We wish to emphasize that the dosages which we have used have been purely empirical. One gram of dried bile is the equivalent of approximately nine grams of gallbladder bile. Since this is real hunger bile and hence quite concentrated, one gram is equal to at least 90 c.c. of liver bile using the figures of Rous and McMaster<sup>10</sup> regarding the concentrating activity of the gallbladder. It is estimated that the average output of bile from the liver is approximately 300 c.c. to 500 c.c. Therefore, it may be seen that if four grams of dried bile are given, sufficient bile will be replaced into the system.

In conclusion, it may be stated that the dried bile preparation described has proven

useful in correcting anorexia and other symptoms associated with biliary disorders. It also makes available a satisfactory preparation which can be used whenever additional bile is indicated.

We are deeply indebted to Dr. Richard McKean and the Department of Internal Medicine at the Detroit Receiving Hospital for their assistance and the use of some of their clinical material.

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## CONVULSIONS OCCURRING DURING NITROUS OXIDE-OXYGEN ANESTHESIA\*

With Report of a Case

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The administration of a general anesthetic, be it either nitrous oxide-oxygen, ether, or a combination of both, must always be of serious concern to the surgeon because of the fact that one never knows in advance the precise manner in which the patient will react to the anesthetic. Although today nitrous oxide-oxygen anesthesia is considered to be a safe procedure, yet of late there have appeared in the medical literature reports of cases having developed convulsions during nitrous oxide-oxygen anesthesia with fatal terminations, either immediately or at a later period following an interval of unconsciousness. Convulsions caused by nitrous oxide-oxygen may develop any time during the period of anesthesia, or even

several hours after the administration of the anesthetic. In practically all cases reported the patient who appeared to be doing well under the anesthetic, suddenly and without warning developed difficulty in respiration,

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with or without cyanosis, and soon manifested tremors, twitchings, rigidity and generalized convulsions as a terminal event.

Mrs. C. S., aged thirty-one, had, as her chief complaint, pain in the left lower abdominal quadrant two and one-half years duration. Examination revealed a relaxed perineum and several external hemorrhoids. On bimanual examination, the uterus was retroverted and there was tenderness of the left adnexa. A tentative diagnosis of laceration of the perineum, external hemorrhoids, retroversion of the uterus and chronic left salpingitis was made and the patient was sent in to the Highland Park General Hospital for operation. Her general condition was good. The heart and lungs were normal. Blood pressure, 110/65. The urine was normal. Hemoglobin, 85 per cent. Red blood count—4,660,000. White blood count—11,800. F. 62. N. F. 13. Endo. 2. Lymph. 23. Kahn was negative. There appeared to be no contra-indication for operation. The next morning the patient received by hypodermic injection, morphine sulphate gr  $\frac{1}{4}$  and atropin sulphate gr. 1/150. Nitrous oxide-oxygen anesthesia with a small amount of ether was administered. The induction of the anesthetic was smooth. The patient's color was good. Breathing was normal and the patient tolerated the anesthesia well with the exception of a rapid pulse of 120 which continued throughout the period of anesthesia. Perineorrhaphy and hemorrhoidectomy was performed first. The abdomen was then opened by mid-line incision. The uterus was found to be retroverted. Large varicosities were present in the left broad ligament. The left tube appeared to be chronically inflamed. A left salpingectomy with the removal of the varicosities of the left broad ligament was then performed. The right round ligament was shortened and a routine appendectomy was performed. After the peritoneum was sutured and just as we were closing the fascia, the patient suddenly developed jerky breathing. This was immediately followed by twitching about the mouth and upward rolling of the eyes. The upper extremities developed epileptiform movements. This spread to the lower extremities and finally the muscles of the abdomen manifested twitchings. This convulsion lasted about three minutes. Oxygen and carbon dioxide was administered at once. I was unable to sew up the fascia, and was obliged to suspend the closure temporarily. As soon as the convulsion ceased, I was able to effect the closure without additional anesthesia. The patient's blood pressure dropped from 110/65 to 70/35. The pulse continued to be 120. Respiration—24. Temperature—99°. The patient was returned to bed in fair condition. She was watched carefully during the post-operative period. At 1:00 p. m. of the day of the operation she reacted from the anesthetic and with the exception of headache of which she complained during the post-operative period, she made an uneventful recovery, and left the hospital fourteen days after operation.

### Clinical Discussion

At first we were at a loss as to the cause of this convulsion. After some discussion, however, three differential diagnostic possibilities were considered.

1. *Epilepsy*.—Even under anesthesia an epileptic person may manifest a convulsive seizure. This condition could, however, be ruled out in this instance, inasmuch as the

patient did not give a history of previous seizures.

2. *Embolism*.—Because we were doing surgery on large varicosities in the pelvis it was thought possible that emboli might have lodged in the brain. However, the uneventful convalescence of the patient would likewise rule out embolism as a cause of convulsion in this case.

3. *Nitrous oxide-oxygen anesthesia* appeared then as the possible cause.

It is apropos, at this time, to review the pharmacodynamics of nitrous oxide-oxygen anesthesia.

A. Nitrous oxide has a specific narcotic action on nerve cells.

B. Asphyxia is produced and with it anoxemia. Cyanosis may or may not be present. Asphyxia and cyanosis are not always synonymous.

C. Nitrous oxide has a depressant action on inhibitory and respiratory centers and a depressant action on motor cells.

What, then, are the possible causes of convulsions under nitrous oxide-oxygen anesthesia? We will here attempt to enumerate all such causes as described in the literature on this subject.

Idiosyncrasies and constitutional habitus are mentioned prominently by many. In those cases where a patient develops convulsions within a few seconds or minutes after inhalation of nitrous oxide-oxygen, idiosyncrasy and constitution plays an important rôle.

### Toxicity of Drug

Wilson,<sup>14</sup> foremost anesthetist of England, states that all anesthetics are toxic agents in varying degree, and, therefore, it is not surprising that nitrous oxide possesses some toxicity.

The impurities of nitrous oxide comprise the hydrazines, hydroxylamines and inert nitrogen which may accumulate in the tank. These impurities tend to inhibit normal oxidation in nerve cells and the resulting disturbance of brain tissue respiration may produce convulsions. By tissue respiration we mean the interchange of oxygen and carbon dioxide between the cellular elements and tissue fluid.

The reflex theory implies that pressure on the carotid sinus may send impulses through the vagus to the respiratory center and thus cause difficulty in respiration. Pressure at the angle of the jaw which so many anesthetists resort to should be discontinued



in order to prevent the possible occurrence of this phenomenon.

The United States Public Health workers<sup>8</sup> studied brains of dogs who have been exposed to atmospheres deficient in oxygen. The resulting anoxemia produced severe hyperemia of the brain. Meningeal and cerebral vessels were dilated and there were many petechial hemorrhages. There was severe damage in the neurons of the brain cortex and degenerative changes in the basal ganglia. Tashiro has shown that nervous tissue uses more oxygen and forms more carbon dioxide in proportion than any other body tissue. There is also a difference in the susceptibility of the nerve cells to oxygen deprivation. The cells of the cortex and basal ganglia are the most sensitive; muscular tissue rank second in the utilization of oxygen and formation of carbon dioxide. It is because of this fact that we are able to produce anesthesia and yet maintain life. If nervous and muscular tissue consumed oxygen at the same rate, by the time the patient was unconscious he would be dead, as the muscles including the heart muscle would have ceased to function. This difference between the two tissues in oxygen consumption is the margin of anesthesia.

Neuropathological changes in brain cortex. In 1916, Baldwin<sup>1</sup> was the first to report fourteen fatalities caused by nitrous oxide-oxygen anesthesia. He pointed out the dangers associated with this type of anesthetic. Since then several American surgeons and one European have reported convulsions and deaths attributable to nitrous oxide anesthesia. Caine<sup>4</sup> was the first to mention damage of the brain as an etiological factor of convulsions and death. However, no histological descriptions of the neuro-pathology was advanced by any of them. It remained for Lowenberg<sup>9</sup> and Waggoner of the University of Michigan to be the first to study the histology of three human brains, obtained at autopsy from patients who died of nitrous oxide-oxygen anesthesia. Lowenberg described, in great detail, the gross and microscopic pathological changes in these brains. Most of the neuropathology appeared in the cortex of the brain. There was a dissociation of the normal brain architecture, and fragmentation of the pyramidal cell which involved, mostly, the second, third, fifth and sixth layers of the cortex. There were some perivascular hemorrhages present. Degenerative changes were also dis-

cernible in the basal ganglia. In the cerebellum the Purkinje cells manifested destruction. In May, 1936, Courville,<sup>6</sup> in a very complete, detailed and comprehensive paper, published the results of his extensive studies of thirteen cases who died as a result of nitrous oxide-oxygen anesthesia. In the main he corroborated the findings of Lowenberg and in addition described multiple areas of necrosis in the brain cortex. Pinson<sup>12</sup> claims that the convulsions in his cases were caused by an excess of carbon dioxide in the system. This may very well take place during the administration of nitrous oxide anesthesia by the rebreathing of CO<sub>2</sub> through the bag. Other causes mentioned in the literature are atropin overdosage, histamine bodies liberated by trauma of tissues during the operation and hypoglycemia due to depleted glycogen reserve.

Out of fairness to nitrous oxide anesthesia, it is only proper that we should mention the fact that convulsions also occur under ether anesthesia. Ether has been in general use for ninety years and yet it is singularly peculiar that no mention has been made in the medical literature of the occurrence of convulsions prior to 1925. The original series of ether convulsions occurred at St. Bartholomew's Hospital, in August of 1925. Nine cases were reported with four fatalities. Since then several papers have been published, both here and abroad, notably by Mennell,<sup>11</sup> Pinson,<sup>12</sup> MacKenzie,<sup>10</sup> Clements,<sup>5</sup> Sears,<sup>13</sup> and others. Careful investigations have been carried out to determine the etiological factors responsible for this distressing and dangerous complication. The following deductions can be made from the analysis of cases and from review of the literature on the subject.

It appears that some persons possess an idiosyncrasy (vague as the word may be) to ether and manifest it by developing convulsions. Accessory factors are necessary for the development of convulsions, such as heat, sepsis, or toxemia, youth and impurities of ether; a good grade of ether should be free from impurities, however, under certain conditions, the best of ether can develop impurities after the containers have been opened. For example, when ether is heated or when nitrous oxide gas and oxygen are bubbled through it, ether impurities, consisting of acetaldehyde and peroxide may develop. These by-products tend to inhibit normal oxidation in nerve

cells and the resulting anoxemia of the brain produces the convulsions.

Sepsis or toxemia appears to be a decided contributory factor because many of the convulsions reported occurred in patients with suppurative appendicitis and peritonitis or in patients who were toxic from other causes. MacKenzie<sup>10</sup> explained this phase by assuming that the increased circulation caused by ether carries more toxins to the brain, which causes cerebral irritation. That ether *per se* produces irritation of the brain is of common knowledge, as we observe in the excitement stage of anesthesia, the addition of toxins augments this irritability and may explain the occurrence of convulsions in septic cases.

Another factor which is worth consideration is youth, as a great majority of convulsions were reported in children whose nervous system is quite unstable. However, we have had ether administered for one hour to a four-day-old baby for the repair of a hare lip without the appearance of convulsions. Because this distressing and serious condition occurs abruptly in an inopportune time and because one-third to one-half of cases have a fatal termination, it is essential for the anesthetist, the surgeon and assistants to familiarize themselves with the etiology, symptomatology and treatment of this emergency in order to be able, intelligently, to combat it when it occurs.

### Treatment

From the prophylactic standpoint in the absence of a method whereby one could predict the occurrence of convulsions, it seems desirable to exercise extreme caution in the selection of an anesthetic for each individual. Patients should come to operation in a resigned mental attitude, and no anesthetic should be forced on any patient. I feel, also, that single anesthetics are safer than mixed. Just as in pharmacology we have discontinued the use of shot-gun prescriptions and substituted single drugs whose physiologic action is definitely

known, so in anesthesia, it is probably best to employ a single anesthetic at a time, which will simplify the metabolic changes produced in the body and give us better control of the situation, although, in some instances a combined anesthesia is desirable and of decided benefit. Before administering a general anesthetic to a septic or toxic child, it is well to consider also other types of anesthesia.

Now, as to the curative treatment. This would vary in each case. Whenever possible the anesthetic should be discontinued as soon as convulsions commence and operative manipulations suspended. Anti-spasmodics should be administered at once. If the patient is cyanotic, oxygen and carbon-dioxide should be given. Chloroform, sometimes, has proven beneficial. In one person, dextrose, intravenously, has been given with spectacular results. Calcium gluconate has been used because of its action in reducing hyper-irritability of the neuro-muscular system. In extreme emergency adrenalin can be used to advantage. Last, but not least, it has been suggested by King<sup>8</sup> that intravenous hypnotics, because of immediate absorption, would prove of value.

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DOWNTOWN DETROIT WATERFRONT

## THE CONVENTION CITY

IT IS difficult to find a virgin field of description for physicians and their families who attend the annual meeting of the Michigan State Medical Society, this month, so familiar is everyone with the Metropolitan City of the state. Detroit welcomes you, and your hosts of the Wayne County Medical Society look forward to the pleasure of entertaining you. In spite of the depression which all are feeling to a greater or less degree, medical Detroit will cast aside any pessimism it may feel and the glad hand to its out-of-town guests will be truly genuine.

To the women guests, Detroit's stores will be found as attractive as ever, and who of them does not enjoy an afternoon's shopping? Not only this as a diversion, the

Art Center is within easy reach by automobile or bus.

Detroit has become one of the important education centers of the country. Wayne University, perhaps the largest municipal educational institution of its kind, has grown great with its affiliated medical, law and teachers' colleges. And here the medical reader will be interested in the movement in the Wayne University Medical School which has succeeded the Detroit College of Medicine and Surgery. The older institution emphasized the practical or clinical features of medicine. The Wayne Medical School has undertaken extensive research in the various sciences basic to medicine and surgery. It is a class A school, meeting all the requirements of the Council on Medical Education of the American Medical Association.

The buildings on St. Antoine and Mullett Streets, which house the school, will be familiar to the graduates of the old Detroit College of Medicine and Surgery, but many new faces of full time professors and instructors will be found. The trend towards research is in keeping with the spirit of the



GREENFIELD VILLAGE



## THE CONVENTION CITY

age in Detroit. The rich and varied clinical material which such a large city provides is being used for teaching purposes. Clinics by Wayne County members of the medical profession constitute a postgraduate course throughout the entire year.

Detroit as a manufacturing and industrial center is too well known to require more than mention here.

Of the attractions, Greenfield Village and the Detroit Zoological Gardens are among the most interesting objects in America. Greenfield Village at Dearborn is a historical museum of Americana be-

tion is presented in this number of *THE JOURNAL* in sufficient detail to speak eloquently for itself.

On page 812 of this number of *THE JOURNAL* will be found the program of the Woman's Auxiliary. Beginning with Mon-



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coming more important and valuable with the march of time. The Zoological Gardens out Woodward Avenue show the various animals in a native habitat as nearly as possible. The Gardens have an area of 125 acres served by a miniature narrow gage railway which relieves the spectator of much walking.

For the visiting members at the convention, there is ample opportunity and facilities for golf. In setting forth here a short account of Detroit's interesting pastime facilities, the program of the medical conven-

tion, September 19, and continuing through Thursday, September 22, almost every hour will afford something interesting to the members of the Auxiliary and their guests. Mrs. A. O. Brown, general chairman of the committee of the Woman's Auxiliary, and her committee have been active weeks in advance in the preparation of what will prove to be one of the best programs placed before the Woman's Auxiliary of the Michigan State Medical Society. With the passing of the years, there has been greater and greater need for the Woman's Auxiliary. The educational work the society has attempted cannot be performed by any other group so well as by the doctors' wives. We have in mind particularly the dissemination of popularized medical knowledge as contained each month in *Hygeia*, as well as lectures to lay audiences which are sponsored by county and state branches of the society.



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| 1895—*Victor C. Vaughan, Ann Arbor                 | 1930—*Ray C. Stone, Battle Creek       |
| 1896—*Hugh McColl, Lapeer                          | 1931—*Carl F. Moll, Flint              |
| 1897—*Joseph B. Griswold, Grand Rapids             | 1932— J. Milton Robb, Detroit          |
| 1898—*Ernest L. Shurly, Detroit                    | 1933— George LeFevre, Muskegon         |
| 1899—*A. W. Alvord, Battle Creek                   | 1934— R. R. Smith, Grand Rapids        |
|  | 1935— Grover C. Penberthy, Detroit     |
|  | 1936— Henry E. Perry, Newberry         |

\*Deceased.

# The 1938 Meeting



HENRY COOK, M.D.  
Flint  
*President*



P. A. RILEY, M.D.  
Jackson  
*Speaker, House of Delegates*

## OFFICIAL CALL

THE Michigan State Medical Society will convene in Annual Session in Detroit on September 19, 20, 21, 22, 1938. The provisions of the Constitution and By-laws and the official Program will govern the deliberations.

Henry Cook, M.D.  
President

P. R. Urmston, M.D.  
Chairman of The  
Council

Philip A. Riley, M.D.  
Speaker

Attest: L. Fernald Foster,  
M.D., Secretary



P. R. URMSTON, M.D.  
Bay City  
*Council Chairman*



WM. A. HYLAND, M.D.  
Grand Rapids  
*Treasurer*



L. FERNALD FOSTER, M.D.  
Bay City  
*Secretary*



H. A. LUCE, M.D.  
Detroit  
*President-Elect*



## CONVENTION INFORMATION

## DIRECTORY

Headquarters.....Book-Cadillac Hotel, Detroit  
 Registration and General Assemblies.....  
 Fourth Floor, Book-Cadillac Hotel  
 Press Room .....  
 Parlor F. Fifth Floor, Book-Cadillac Hotel  
 Secretary's Office .....Book-Cadillac Hotel  
 Technical Exhibits .....  
 Fourth Floor, Book-Cadillac Hotel  
 Woman's Auxiliary Headquarters.....  
 Statler Hotel, Detroit

\* \* \*

**Register—Fourth Floor Book-Cadillac Hotel, Detroit—as soon as you arrive.**

Admission by badge only to all General Assemblies and Section Meetings. Monitors at entrance. Bring your A.M.A. or county medical society membership card to expedite registration.

Hours of Registration: Daily 8:30 a. m. to 6:00 p. m. on Monday, Tuesday, Wednesday, and to 4:00 p. m. on Thursday.

No registration fee to members of the Michigan State Medical Society.

\* \* \*

**Seven General Assemblies, Tuesday, Wednesday, Thursday, September 20, 21, 22.**

**Public Meetings:** The Evening Assemblies of Tuesday and Wednesday, September 20 and 21, will be open to the public.

**All Section Meetings** will be held on Wednesday morning only, September 21.

## SYMPOSIUM ON "THE BUSINESS SIDE OF MEDICINE"

Monday, September 19, 1938—3:30 to 5:00 P. M.

English Room (Mezzanine), Book-Cadillac Hotel, Detroit

Arranged for secretaries and office assistants of M.S.M.S. members. Physicians and their wives are cordially welcome.

## Program

Presiding: B. I. Johnstone, M.D., Detroit.

1. "Office Secretary's Psychology with Patients and Visitors" (10 min.)—Henry C. Black, Battle Creek, Michigan.
2. "Importance of Simple and Accurate Records" (10 min.)—Miriam Zion, New York, N. Y.
3. "Collection Procedures" (10 min.)—Frank E. Parker, Detroit, Michigan.

## Round Table Discussion

## CONFERENCE FOR INTERNES AND RESIDENTS

Monday, September 19, 1938—2:30 to 3:30 P. M.

English Room (Mezzanine), Book-Cadillac Hotel, Detroit

All Internes and Residents in Michigan hospitals are cordially invited to be guests of the Michigan State Medical Society at this conference.

## Program

Presiding: H. R. Carstens, M.D., Detroit.

1. "The Value of Medical Organization to the Physician and to the Public," (10 min.)  
R. G. LELAND, M.D., Chicago, Ill., Director, Bureau Medical Economics, A.M.A.



R. G. LELAND, M.D.

2. "The Place of the Michigan State Medical Society in the Young Physician's Life," (10 min.)....  
L. FERNALD FOSTER, M.D., Bay City, Secretary, Michigan State Medical Society.

3. "Pitfalls of the Practice of Medicine—Practical Pointers," (20 min.).....  
J. M. ROBB, M.D., Detroit, Past-President, Michigan State Medical Society.

## Round Table Discussion

This Conference will be followed immediately by the symposium on "The Business Side of Medicine." Conferees are urged to remain for this valuable session.

\* \* \*

**Physicians, not members,** if listed in the American Medical Directory, may register as guests upon payment of \$5.00. (This amount will be credited to them as dues in the Michigan State Medical Society *for the balance of 1938 only*, provided they subsequently are accepted as members by their County Medical Society.)

**Technical Exhibits** open Tuesday, September 20, at 8:30 A. M., and on Wednesday and Thursday at the same hour. Exhibits close Tuesday and Wednesday at 6:00 P. M.; Thursday at 3:30 P. M. Intermissions to view the exhibits have been arranged during the morning and afternoon General Assemblies.

## ATTENTION GOLFERS!

The golf tournament scheduled for the Tam O'Shanter Club on Sunday, September 18, has been cancelled due to the special and important meeting of M.S.M.S. delegates on that date.

## COUNTY SECRETARIES' CONFERENCE

English Room Book-Cadillac Hotel

TUESDAY, SEPTEMBER 20, 1938

5:30 to 8:00 P. M.

John J. McCann, M.D., Ionia, Presiding



### "The Physician and the Public."

WM. S. SADLER, M.D.

*Dr. Sadler is a practitioner of more than thirty years experience, formerly professor at the Postgraduate Medical School of Chicago, Director and Chief Psychiatrist of the Chicago Institute of Research and Diagnosis, Consulting Psychiatrist Columbus Hospital, Consultant in Psychiatry, the W. K. Kellogg Foundation.*

WM. S. SADLER, M.D.

*He is the author of numerous psychiatric works, including "Theory and Practice of Psychiatry," "Psychiatric Nursing," "The Mind at Mischief," etc.*

*The Doctor is a Fellow of the American Medical Association, the American Psychiatric Association, and a member of the American Psychopathological Association.*

*By both his writings and his lectures the doctor has been a consistent advocate of broad and rational principles of psychiatry, and was among those writers who early placed emphasis upon the importance of the preventive aspects of mental hygiene.*

REFRESHMENTS

DINNER

All Members of the State Society Will Be

Welcome at This Conference.

- 2:30 P. M. Conference for Residents and Internes.  
English Room, Book-Cadillac Hotel.
- 3:00 P. M. Second Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.
- 3:30 P. M. Symposium on "Business Side of Medicine."  
English Room, Book-Cadillac Hotel.
- 8:00 P. M. Third Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.

## TUESDAY, SEPTEMBER 20

- 8:30 A. M. Registration; Exhibits Open.  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M. First General Assembly.  
Grand Ballroom, Book-Cadillac Hotel  
(For detailed program, see page 816.)
- 12:30 P. M. Committee Organization Luncheon.  
Chairmen of 1938-39 Committees.  
Parlor H, Book-Cadillac Hotel.
- 1:30 P. M. Second General Assembly.  
Grand Ballroom, Book-Cadillac Hotel.  
(For detailed program, see page 817.)
- 5:30 P. M. County Secretaries Conference.  
English Room, B-C Hotel.
- 8:00 P. M. Third General Assembly.  
Grand Ballroom, B-C Hotel.  
PUBLIC MEETING. (For detailed program, see page 818.)

## WEDNESDAY, SEPTEMBER 21

- 8:30 A. M. Registration; Exhibits Open.  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M. Meetings of Sections:  
General Medicine  
English Room, B-C Hotel (see page 814.)  
Surgery  
Grand Ballroom, B-C Hotel (see page 814.)  
Gynecology and Obstetrics  
Washington Room, B-C Hotel (see page 814.)  
Ophthalmology  
Founders Suite, B-C Hotel (see page 814.)  
Otolaryngology  
Parlors G, H, I, B-C Hotel (see page 814.)  
Pediatrics  
Parlor '06-'07, Book-Cadillac Hotel (see page 816.)  
Dermatology & Syphilology  
Harper Hospital (see page 816.)
- 12:30 P. M. Preventive Medicine Committee Reunion Luncheon.  
English Room, B-C Hotel.
- 12:30 P. M. Maternal Health Committee's Luncheon.  
Washington Room, B-C Hotel.
- 1:30 P. M. Fourth General Assembly.  
Grand Ballroom, B-C Hotel.  
(For detailed information see page 819.)
- 8:00 P. M. Fifth General Assembly.  
Grand Ballroom, B-C Hotel.  
PUBLIC MEETING. (For detailed information see page 820.)

## THURSDAY, SEPTEMBER 22

- 8:30 A. M. Registration; Exhibits Open.  
Fourth Floor, Book-Cadillac Hotel.
- 9:30 A. M. Sixth General Assembly.  
Grand Ballroom, B-C Hotel.  
(For detailed information, see page 820.)
- 1:30 P. M. Seventh General Assembly.  
Grand Ballroom, B-C Hotel.  
(For detailed information, see page 821.)
- 5:00 P. M. End of Convention.

Essayists are very respectfully requested not to change time of lecture with another speaker, without the approval of the General Assembly. This request is made in order to avoid confusion and disappointment on the part of the audience.

## PROGRAM SYNOPSIS

### SUNDAY, SEPTEMBER 18

- 1:00 P. M. Third Annual Golf Tournament.  
Tam O'-Shanter Country Club
- 6:30 P. M. Meeting of The Council, M.S.M.S.  
Founders Suite, Book-Cadillac Hotel.
- 7:00 P. M. Golfers Banquet. Presentation of Prizes.  
Tam O'-Shanter Country Club

### MONDAY, SEPTEMBER 19

- 8:00 A. M. Delegates' Breakfast.  
English Room, Book-Cadillac Hotel.
- 9:00 A. M. First Session, House of Delegates.  
Grand Ballroom, Book-Cadillac Hotel.



# Woman's Auxiliary



MRS. G. C. HICKS, Presiding

## 6:00 P.M. Banquet—Statler Hotel, Detroit

Presiding Officer—Mrs. G. C. Hicks

Chairman—Mrs. A. O. Brown  
Short Talk—Morris Fishbein, M.D.,  
Chicago, Advisory Council, A.A.  
M.A.

Honor Guests—Mrs. Chas. Tomlinson,  
National President, A.A.M.A.; Mrs.  
Guy L. Kiefer, Honorary Presi-  
dent, A.M.S.M.S.; and Mrs. Morris  
Fishbein

Speaker—Mrs. Lawrence Hess  
Subject: "Social Hygiene"

## 8:30 P.M. Bridge—Statler Hotel

### MRS. A. O. BROWN

*General Chairman  
of Committee of the  
Woman's Auxiliary  
for the 73rd Annual  
Convention of the  
Michigan State Medi-  
cal Society, Detroit,  
Michigan.*



## OFFICERS, 1937-38

Mrs. G. C. Hicks, Jackson.....President  
Mrs. P. R. Urmston, Bay City.....President-Elect  
Mrs. L. G. Christian, Lansing.....Vice President  
Mrs. J. W. Page, Jackson.....Secretary-Treasurer  
Mrs. A. V. Wenger, Grand Rapids...Past President  
Mrs. Guy L. Kiefer, East Lansing.....  
Honorary President

## PROGRAM

### MONDAY, SEPTEMBER 19, 1938

#### 3:00 to 4:30 P.M. Office Secretaries' Confer- ence

English Room, Book-Cadillac Hotel,  
Detroit

Symposium on the "Business Side of  
Medicine." Secretaries, doctors'  
wives and other interested indi-  
viduals invited.

Three ten-minute talks and round-  
table discussion.

### TUESDAY, SEPTEMBER 20, 1938

#### 10:00 A.M. Registration—Statler Hotel, De- troit

#### 1:00 P.M. Luncheon, Pre-Convention Board Meeting

Statler Hotel, Detroit  
1937-38 Board Members and County  
Presidents

### WEDNESDAY, SEPTEMBER 21

#### 10:00 A.M. Business Session, Statler Hotel, Detroit

All doctors' wives of the state are  
urged to attend

Presentation of pins, Mrs. Chas. Tom-  
linson, Omaha, Neb., National  
President, A.A.M.A.

#### 1:00 P.M. Luncheon—Colony Club

Guests—Mrs. Chas. Tomlinson  
National President, A.A.M.A.

—Henry Cook, M.D., Flint,  
Retiring President, M.S.M.S.

—H. A. Luce, M.D., Detroit,  
President, M.S.M.S.

—President-elect, M.S.M.S.  
(Name to be announced)

—L. Fernald Foster, M.D., Bay  
City, Secretary, M.S.M.S.

—H. R. Carstens, M.D., Detroit,  
President, Wayne County  
Medical Society

Speaker—H. S. Collisi, M.D., Grand  
Rapids, Chairman, Advisory  
Committee, W.A.M.S.M.S.

Subject: "Marriage After  
Forty"

#### 4:00 P.M. Post-convention Board Meeting

Mrs. P. R. Urmston presiding  
1938-39 Board Members

### THURSDAY, SEPTEMBER 22, 1938

#### 10:30 A.M. Fashion Show

THE 1938 MEETING



FRANK H. LAHEY, M.D.



H. O. JONES, M.D.



J. E. MOORE, M.D.



H. A. CHRISTIAN, M.D.



A. D. RUEDEMANN, M.D.

Guest  
Speakers



JOHN E. GORDON, M.D.



Detroit  
1938



F. J. TAUSSIG, M.D.

(Additional photographs on Page 815)



S. J. SEEGER, M.D.



O. V. BATSON, M.D.



J. A. BARGEN, M.D.



M. FISHBEIN, M.D.



WM. D. McNALLY, M.D.



C. A. ALDRICH, M.D.



# PROGRAM of SECTIONS

## WEDNESDAY MORNING

September 21, 1938

### SECTION ON GENERAL MEDICINE

English Room, Mezzanine Floor,  
Book-Cadillac Hotel

Chairman: WM. L. BETTISON, M.D., Grand Rapids  
Secretary: DOUGLAS DONALD, M.D., Detroit

#### A. M.

- 9:30 Massive Collapse of the Lung  
DAVID I. SUGAR, M.D., Detroit
- 10:00 A New Interpretation of Diabetes Mellitus in Obese Middle-Aged Patients. Recovery by Reduction of Weight  
JEROME W. CONN, M.D., Ann Arbor
- 10:30-11:00 Election of Officers
- 11:00 Sulfanilamide  
GORDON MYERS, M.D., Detroit
- 11:30 Fever of Undetermined Origin  
DONALD S. SMITH, M.D., Pontiac
- 12:00 Bromide Intoxication  
RAYMOND W. WAGGONER, M.D., Ann Arbor

### SECTION ON SURGERY

Grand Ballroom, Fourth Floor  
Book-Cadillac Hotel

Chairman: WM. R. TORGERSON, M.D., Grand Rapids  
Secretary: M. D. WERTENBERGER, M.D., Jackson

#### A. M.

- 9:00 to 9:30 A Combined Operation for Cancer of the Rectum  
FRED W. RANKIN, M.D., Lexington, Ky.
- 9:30 to 10:00 The Treatment of Burns  
STANLEY J. SEEGER, M.D., Milwaukee
- 10:00 to 10:30 Limitations of Transurethral Prostatectomy  
REED M. NESBIT, M.D., Ann Arbor
- 10:30 to 11:00 Hemorrhoidectomy Under Regional Anesthesia (illustrated by slides and colored moving pictures)  
LOUIS J. HIRSCHMAN, M.D., Detroit
- 11:00 to 11:30 Knee Joint Injuries Exclusive of Fracture (with lantern slides)  
KELLOGG SPEED, M.D., Chicago

11:30 to 12:00 Election of Officers

#### P. M.

- 12:00 to 12:30 The Problems of Severe Hyperthyroidism  
WALTER G. MADDOCK, M.D., Ann Arbor

### SECTION ON GYNECOLOGY AND OBSTETRICS

Washington Room, Fifth Floor  
Book-Cadillac Hotel

Chairman: NORMAN R. KRETZSCHMAR, M.D., Ann Arbor  
Secretary: CLARENCE TOSHACH, M.D., Saginaw

#### A. M.

- 9:00 to 9:30 Radiation Therapy in Benign Pelvic Lesions  
NORMAN R. KRETZSCHMAR, M.D., Ann Arbor
- 9:30 to 10:00 Cesarean Section in Detroit  
WARD F. SEELEY, M.D., Detroit
- 10:00 to 11:00 Lymph Gland Removal in Cervix Cancer; Technics and Results  
FRED TAUSSIG, M.D., St. Louis
- 11:00 to 11:30 Maternal Health Survey in Michigan  
ALEXANDER M. CAMPBELL, M.D., Grand Rapids
- 11:30 to 12:30 Prolapse of the Uterus  
JOSEPH BAER, M.D., Chicago
- Election of Officers

### SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman: DEWEY R. HEETDERKS, M.D., Grand Rapids  
Secretary: O. B. MCGILLICUDDY, M.D., Lansing

#### OPHTHALMOLOGY

Founders' Suite, Fifth Floor  
Book-Cadillac Hotel

#### A. M.

- 9:30 to 10:45 Ophthalmological Round Table, to be conducted by  
A. D. RUEDEMANN, M.D., Cleveland
- Subject: "Endocrine Disturbances Pertaining to the Eye"
- Same subject to be repeated 11:00 A. M. to 12:15 P. M. in order that all section members may hear both papers. Members of this section are invited to change to Parlor G-H-I at 10:45 A. M. to hear Doctor Batson.

#### OTOLARYNGOLOGY

Parlors G-H-I, Fifth Floor  
Book-Cadillac Hotel

#### A. M.

- 9:30 to 10:45 Otolaryngological Round Table, to be conducted by  
O. V. BATSON, M.D., Philadelphia
- Subject: "The Surgical Anatomy of the Ear"
- Same subject to be repeated 11:00 A. M. to 12:15 P. M. in order that all section members may hear both papers. Members of this section are invited to change to the Founders' Suite at 10:45 A. M. to hear Doctor Ruedemann.

#### P. M.

- 12:30 Luncheon for Members of the Section on Ophthalmology and Otolaryngology. Founders' Suite, Book-Cadillac Hotel.
- Election of Officers

It is important that those planning to attend the luncheon notify the Secretary at once as all places will be reserved.

THE 1938 MEETING



F. G. EBAUGH, M.D.



F. E. ADAIR, M.D.



J. L. BAER, M.D.



H. F. HELMHOLTZ, M.D.



R. L. HADEN, M.D.

# Guest Speakers



KELLOGG SPEED, M.D.



KATHARINE LENROOT

# Detroit 1938



R. D. MUSSEY, M.D.



R. GRINKER, M.D.  
SEPTEMBER, 1938



F. D. RANKIN, M.D.



H. CASPARIS, M.D.



A. F. VOSHELL, M.D.



HOWARD FOX, M.D.



SECTION ON PEDIATRICS

Parlor '06-07 (See Bulletin Board, Fourth floor) Book-Cadillac Hotel

Chairman: ALLAN L. RICHARDSON, M.D., Detroit  
Secretary: WARD L. CHADWICK, M.D., Grand Rapids

A. M.

9:00 to 9:30 A Ten Year Study of Nine Hundred Reactors to Tuberculin with Particular Reference to Their Experience at Puberty

JOSEPH A. JOHNSTON, M.D., Detroit

9:30 to 9:45 Four Years' Experience with Whooping Cough Immunization

WARD L. CHADWICK, M.D., Grand Rapids

9:45 to 10:00 Experiences with Over Four Hundred Whooping Cough Immunizations

EDGAR E. MARTMER, M.D., Detroit

10:00 to 10:15 Experiences in the Treatment of One Hundred Cases of Erysipelas with Sulfanilamide

FRANKLIN H. TOP, M.D., Detroit

10:15 to 11:00 The Flat Foot Problem in Childhood (with clinical cases)

FREDERICK J. FISCHER, M.D., Detroit

11:00 to 11:15 Tetany in the New Born

JOHN L. LAW, M.D., Ann Arbor

11:15 to 12:00 The Management of Critical Situations in Childhood Nephritis

C. A. ALDRICH, M.D., Winnetka, Ill.

Election of Officers

SECTION ON

DERMATOLOGY AND SYPHILOLOGY

Harper Hospital, Detroit

Chairman: GEO. VAN RHEE, M.D., Detroit  
Secretary: RUTH HERRICK, M.D., Grand Rapids

A. M.

9:00 to 10:15 Clinic at Harper Hospital, 3839 Brush Street, Detroit

10:15 to 10:45 Discussion of cases presented

10:45 to 11:00 Chairman's Address

GEORGE VAN RHEE, M.D., Detroit

11:00 to 11:20 Mouth Lesions

ARTHUR WOODBURN, M.D., Grand Rapids

11:20 to 11:40 Skin Disturbance in Nervous Patients

MILTON G. BUTLER, M.D., Saginaw

11:40 to 12:00 Treatment of Urticaria and Allied Dermatoses

CLAUD W. BEHN, M.D., Detroit

P. M.

12:00 to 12:20 Discussion

12:20 to 12:30 Election of officers

PROGRAM of GENERAL ASSEMBLIES

TUESDAY MORNING

September 20, 1938

First General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

HENRY R. CARSTENS, M.D., Presiding  
L. FERNALD FOSTER, M.D., and DOUGLAS DONALD, M.D., Secretaries

A. M.

9:30 "The Management of Surgical Conditions of the Common Bile Duct"

FRANK H. LAHEY, M.D., Boston, Mass.

*Harvard Medical College, 1904; Professor of Surgery, Tufts Medical School, 1913-17; Director of Surgery, A.E.F. Evacuation Hospital No. 30; Major, Medical Corps, World War; Professor of Clinical Surgery, Harvard Medical School, 1923-24. At present, Director of Lahey Clinic, Boston; Surgeon-in-Chief, New England Deaconess Hospital; Surgeon-in-Chief, New England Baptist Hospital; President, American Association for the Study of Goiter; member, American Surgical Society, International Surgical Society.*

In three thousand operations for gallstones, the following deductions have been made. The mortality of gallstones is largely related to prolonged infection and stones within the bile ducts. These

are the result of late operations for gallstones. The fatality factors in operations for gallstones exclusive of acute cholecystitis, are jaundice, hemorrhage, liver infection and diminished liver function.

Operations for gallstones, to insure the most complete relief, postoperatively, should consist in removal of the gall bladder and in addition, removal of all stones from the common and hepatic ducts, together with prolonged drainage of the biliary tree when infection is present. Indications for opening and investigating the common and hepatic ducts will be stated and this plan insures the least morbidity and the lowest mortality.

10:00 "Tubal Pregnancy"

HAROLD O. JONES, M.D., Chicago, Ill.

*Professor of Gynecology, Northwestern University Medical School; Senior Gynecologist and Chairman of the Department of Obstetrics and Gynecology, St. Luke's Hospital.*

A series of lantern slides are used to develop the idea of explaining the events in tubal pregnancy, based upon the progressive pathology. The fact that implantation is the same wherever it may take place is used to demonstrate the serious accidents that occur in tubal pregnancies.

A series of photomicrographs are used to outline the trochoblastic activity of the chorion, and also the lack of defense in the tissues not especially prepared for the reception of the fertilized ovum.

A third group of slides gives in detail the statistical data concerning the occurrence of the important symptoms.

**TUESDAY MORNING****September 20, 1938****10:30 INTERMISSION TO VIEW THE EXHIBITS****11:00 "Syphilitic Primary Optic Atrophy"**

JOSEPH E. MOORE, M.D., Baltimore, Md.

M.D., Johns Hopkins, 1916; First Lieutenant and Captain, Medical Corps, A.E.F., 1917-19; successively Assistant, Instructor and Associate in Medicine, Johns Hopkins University, 1919 to present; Physician-in-Charge, Syphilitic Division, Medical Clinic, 1930 to present; Assisting Visiting Physician, Johns Hopkins Hospital; Member, American Society for Clinical Investigation, Association of American Physicians, American Clinical and Climatological Society; Special Consultant, U. S. Public Health Service; Consultant in Venereal Diseases, Maryland State Health Department.

Syphilitic eye condition, if untreated, always results in blindness in both eyes. With routine treatment the blindness of a few patients is delayed, but with special forms of treatment, well known to doctors in this field, the patient may be totally protected from this complication of syphilis.

**11:30 "Certain Cardiorenal Circulatory Correlations"**

HENRY ASBURY CHRISTIAN, M.D., Boston, Mass.

Johns Hopkins, 1900; Sc.D., Jefferson, 1928; LL.D., Randolph-Macon, 1923, and from Western Reserve, 1931; F.R.C.P. (Hon.), Canada, 1936; Instructor in Pathology, Harvard, 1902-05; in charge of medical students, Massachusetts General Hospital, 1905-07; Hersey Professor, Theory and Practice of Physics, Harvard, since 1908; Dean, Faculty of Medicine and Medical School, Harvard, 1908-12; Fellow Am. Acad., 1913; Corr. member, Wiener Gesellschaft f. innere Medizin, etc., 1923; Corr. member, Medico-Chirurgical Soc., Edinburgh, 1937; former Major, M.R.C., U. S. Army; Resident Chairman, Div. of Med. Sciences, Nat. Research Council, Washington, D. C., 1919-20; Physician-in-Chief, Peter Bent Brigham Hospital, Boston, since 1910.

In all the forms of kidney lesions, as here described, the cardiocirculatory correlations play a dominant part in causing their symptoms and physical signs. Part of the proper treatment of Bright's disease, especially the chronic forms, must concern itself with the therapeutic management of the circulation; this may be, and often is, the part of the treatment that yields the best results. The physician ever should keep in mind three facts: (1) that the general circulation disturbs renal function; (2) that disturbed renal function, the result of intrarenal lesions, has an injurious effect on general circulation; (3) that there is a close correlation between extrarenal and intrarenal circulation, each in an important way influencing the other, the two together productive of the physical signs and symptoms which we encounter in our patients whose urine shows departures from normal in specific gravity, albumin content and appearance in the sediment of casts and cells. Very simple methods of history taking, physical examination and urine study, all of which can be carried out by any well trained physician in his office, suffice for an adequate understanding of the clinical problems and for a proper therapeutic management of patients with chronic Bright's disease.

**12:00 "Headaches and Head Pains of Ocular Origin"**

A. D. RUEDEMANN, M.D., Cleveland, Ohio

M.D., University of Michigan, 1921; Head of Eye Department, Cleveland Clinic, since 1924; Secretary, Teachers' Section, American Academy of Ophthalmology and Otolaryngology; Secretary of Instruction in Ophthalmology American Academy of Ophthalmology and Otolaryngology;

The eyes play a very important part in the production of headaches and head pains. Prop-

er examination of the eyes rather than fitting of glasses is necessary in order to differentiate the different types of pain that are primarily due to muscular pathology from that pain or headache that is secondary to eyestrain.

From the medical viewpoint in the case of every patient who presents himself with a headache, the eyes should be examined, for in some instances very minor eye changes cause terrific headaches although in other instances high refractive errors produce no headaches at all. Better and more complete examination of the eyes by the practitioner is indicated in most cases of headaches but a great many causes of headache can be ruled out by a few simple maneuvers. The eyes frequently afford the clue to the solution of the problem presented by the patient and it is wise to make use of the experience gained from the examination of the various eyes as they are presented for differential diagnosis. Although the patient may wear glasses, it does not follow that all abnormal conditions in the eyes have been corrected. Muscle instability and intraocular pathology cause a considerable amount of headache. The entire subject of headache as related to the eyes is one of importance and interest and affords an excellent field for treatment. The patients usually obtain a great deal of relief from very ordinary procedures.

**P. M.****12:30 End of First General Assembly Luncheon—****VIEW THE EXTRAORDINARY EXHIBIT****TUESDAY AFTERNOON****September 20, 1938****Second General Assembly****Grand Ballroom, Fourth Floor, Book-Cadillac Hotel**

VERNOR M. MOORE, M.D., Presiding  
L. FERNALD FOSTER, M.D., and MORRIS D. WERTENBERGER, M.D., Secretaries

**P. M.****1:30 "Babies Are Human Beings"**

C. A. ALDRICH, M.D., Winnetka, Ill.

Associate Professor of Pediatrics, Northwestern University Medical School; Associate Physician and Chairman, Pediatric Department, Evanston Hospital; Associate Attending Physician, Children's Memorial Hospital.

The more we study human growth and development, the more we realize that babies are something very different from our traditional idea of them, and that somewhere along the line, we have failed to appreciate the peculiar value of their fundamental human qualities. It is only when we look at them against a developmental background that we begin to see them in proper perspective; as products of their evolutionary past, as dynamic living creatures and as potential adults.

In this presentation, an attempt will be made to interpret the behavior of newly born babies in the light of their purposeful nature, and to consider some of the individual differences at this age. Time will permit only the merest mention of how growth processes continually change these babies, as they grow into our complex society.

**2:00 "Common Lesions of the Vulva"**

FRED J. TAUSSIG, M.D., St. Louis, Mo.

Harvard, A.B., 1893; Washington University, M.D., 1898; President, Central Association of Gynecology and Obstetrics, 1929; President, American Gynecological Society, 1937; Gynecologist, Barnard Free Skin and Cancer Hospital, 1906-



## TUESDAY AFTERNOON

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1938; Professor of Clinical Obstetrics, Washington University School of Medicine.

The vulva is a part of the skin covering the body, but also a part of the genital tract, and influenced by the ovarian hormones. Hence we have a variety of skin lesions found elsewhere such as dermatitis, furunculosis, etc., and also certain specific genital changes such as leukoplakic vulvitis. In addition, the vulva is not uncommonly infected by venereal disease. Gonorrhea produces vulvo-vaginitis in children and Bartholin abscess or cyst after puberty. Syphilis produces characteristic primary sores, mucous patches, and gummata. Of special interest are the chronic hypertrophies associated with lymphogranuloma and granuloma inguinale. In the field of neoplasms by far the most important is carcinoma, developing usually on a pre-existing leukoplakia. In spite of relative infrequency it is very important because with prompt diagnosis and proper treatment (complete vulvectomy and lymph gland removal) we can expect a five-year cure in two-thirds of the patients.

#### 2:30 "The Treatment of Burns"

STANLEY J. SEEGER, M.D., Milwaukee, Wis.

M.D., Northwestern University, 1917; Chief of Columbia Hospital, Milwaukee Children's Hospital; Chairman, Council on Industrial Health, American Medical Association.

Burns constitute an important medical and surgical as well as economic problem. Since the introduction of tannic acid by Davidson, in 1925, there has been a great revival of interest in the various problems presented. The cause of so-called toxic burn shock is not clear. The relief of pain, blood transfusion, the replacement of lost fluids and chlorides, the application of external heat, in addition to proper local care of the wound, are important factors in a program of treatment.

Since more attention has been paid to the treatment of burns more patients are carried through the immediate acute stage and develop large granulating wounds. The derma, or true skin, is derived from the mesoderm and is, therefore, a tissue which is not designed to serve as a source of epithelial development. A well established principle in the treatment of large granulating wounds is that an attempt should be made to cover them with epithelium at the earliest possible moment. Delay in epithelization means an increase in scar tissue and greater deformity.

Large granulating wounds present difficult problems in the control of infection, the maintenance of nutrition and the general care of the individual.

#### 3:00 INTERMISSION TO VIEW THE EXHIBITS

#### 3:30 "Hearing and Deafness"

OSCAR V. BATSON, M.D., Philadelphia, Pa.

M.D., St. Louis University, 1920. Instructor in Anatomy, University of Wisconsin, 1920-21; Assistant Professor, Associate Professor and Professor of Anatomy, University of Cincinnati, 1921-28; Professor of Anatomy, Graduate School of Medicine, University of Pennsylvania since 1928; Instructor in Otolaryngology, School of Medicine, University of Pennsylvania, since 1936; Staffs Graduate Hospital, University Hospital and Philadelphia General Hospital; Member, American Association of Anatomists, The American Academy of Ophthalmology and Otolaryngology.

So much effort has been focused upon the obviously deafened that a slight degree of hearing deficiency might be assumed to be but a slight handicap. Many cases of small loss of hearing acuity as shown by testing methods have, for practical purposes of daily life, an almost total disability. Efforts should be made to decide upon the relative disability as well as the absolute hearing loss. The principal disabling factor in a "mixed deafness" should be determined if possible.

If suited, hearing devices should be advised and the patient helped to adjust himself. The introduction of hearing aids into the schools can help pupils with a slight reduction in hearing acuity and they will help to break down the prejudice against hearing aids.

#### 4:00 "The Management of the Various Types of Ulcerative Colitis"

J. ARNOLD BARGEN, M.D., Rochester, Minn.

Associate Professor of Medicine, Mayo Foundation; Consultant in Medicine, Mayo Clinic; in charge of Intestinal Service, St. Mary's Hospital; Member, American Gastro-Enterological Association, Central Society for Clinical Research, Pan-American Medical Association, International Gastro-Enterological Association, etc.

There are many different forms of colitis. Tuberculous colitis has been generally recognized since the turn of the century. During the second decade of this century, the pandemic, epidemic, and endemic possibilities of bacillary colitis and amebiasis were discovered. During the third decade of this century, streptococcal ulcerative colitis was described as an entity. Many other types of ulcerative colitis are now known. Among them, that kind in which some bodily deficiency plays a rôle should be mentioned. Also regional enteritis and many other forms of inflammatory ulcerative disease of the colon are recognized. Each of these and their management will be discussed briefly.

The term "colitis" should be applied to an intestinal condition only when demonstrable inflammation is at hand. Hence, the term "mucous colitis" is no longer tenable.

#### 4:30 End of Second General Assembly

THE EXHIBITS WILL REMAIN OPEN UNTIL  
6:00 P. M.

## TUESDAY EVENING

### September 20, 1938

#### Third General Assembly

#### Public Meeting

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

HENRY A. LUCE, M.D., Presiding  
L. FERNALD FOSTER, M.D., and C. S. TOSHACH, M.D., Secretaries

#### POSTGRADUATE CONVOCATION

P. M.

- 8:00 1. Music by Wayne County Medical Society Glee Club
2. Call to Order
3. (a) "The Challenge of Medical Service"

JAMES D. BRUCE, M.D., Ann Arbor, Mich.

Vice President in Charge of University Relations, University of Michigan; Chairman, Committee on Postgraduate Medical Education, Michigan State Medical Society.

- (b) Presentation of Certificates of Associate Fellowship in Postgraduate Education, Michigan State Medical Society

#### 8:30 4. "Social Aspects of Medical Care"

MORRIS FISHBEIN, M.D., Chicago, Ill.

Rush Medical College, 1912; Editor, the Journal, A.M.A.; Hygeia; Associate Clinical Professor of Medicine, University of Chicago; Lecturer, History of Medicine, University of Illinois School of Medicine; author of many significant contribu-

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tions to medical and lay literature; Member, Chicago Pathological Society, Institute of Medicine, American Association for the Advancement of Science.

Increasing entrance of government into medical practice. The national health program of the interdepartmental committee. Factors in development of present government plans. Political aspects of the problem of medical care. The future of medical practice in the United States.

10:00 End of Third General Assembly

## WEDNESDAY AFTERNOON

### September 21, 1938

#### Fourth General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

DON. W. GUDAKUNST, M.D., Presiding  
L. FERNALD FOSTER, M.D., and O. B. MCGILLICUDDY, M.D., Secretaries

#### PREVENTIVE MEDICINE

P. M.

1:30 "Carbon Monoxide Poisoning"

WM. D. McNALLY, M.D., Chicago, Ill.

M.D., Rush Medical College, 1920; Instructor in Chemistry, U. of Ill., 1905-06; Assoc. Prof. Materia Medica and Toxicology, Rush Med. College since 1923; Chief Chemist and Toxicologist, Cook County Coroner, 1913-29; Attending Physician Presbyterian Hospital, St. Joseph's Hospital, Chicago; General practice of medicine since 1920, Chicago; Appointed Lt. Col. Chem. Warfare, Reserve Corps, U. S. A.; Member Am. Chem. Society; Author of chapters on gas poisons, detection of blood stains in Peterson, Haines and Websters' Toxicology and Legal Medicine; also author of textbook on Toxicology.

Carbon monoxide is a modern poison with an historical record dating back twenty-five centuries. Deaths from this poison, in the home and in industry, increased each year until natural gas and the extensive use of electricity were introduced. Natural gas does not contain carbon monoxide, but as a source of heat and illumination it is usually mixed with 2 to 3 per cent of carbon monoxide.

Deaths from the exhausts of automobiles are on the increase and in all probability many accidents upon the highways are due to the effects of this insidious gas, which is colorless, odorless and tasteless. The literature contains abundant references to coronary lesions due to carbon monoxide intoxication. Poisoning by this gas may be acute or chronic, the symptoms and pathology vary depending upon the amount of gas absorbed and the length of time of exposure. Diagnosis of carbon monoxide poisoning is often very easy, sometimes difficult and never positive unless a chemical examination of the blood is made. The symptoms may simulate many conditions other than that of poisoning by this gas, thus leading to errors in diagnosis. Poisoning in private garages in winter is absolutely preventable, if certain measures are applied to the exhaust gas whereby it is discharged into the open air.

2:00 "The Obligations of the Medical Profession in Relation to Mental Health"

FRANKLIN G. EBAUGH, M.D., Denver, Colo.

Johns Hopkins University, 1919. Director Colorado Psychopathic Hospital and Professor of Psychiatry, University of Colorado Medical School,

since 1924; Director of Division of Psychiatric Education, National Committee for Mental Hygiene, since 1933; Member, American Board of Psychiatry and Neurology; Consultant at Large in Mental Hygiene in the U. S. Public Health Service.

One of the most constructive aspects of the Mental Hygiene movement in this country has been the impetus and critical guidance it has given to medical education. By means of more intensive and thorough psychiatric teaching in the medical curriculum, the students of today are better prepared to recognize, understand and help the great number of patients who suffer from some type of personality disorder.

Mental Hygiene should enable the physician to understand himself better; it should lead to a greater enrichment of life and to a sympathetic understanding of the problems of others.

Indirectly it should enable him to care for the many baffling problems which are called "functional" which may or may not be associated with physical illness. It should also help him to understand the social or cultural pattern of the sick person in relation to his family, friends and fellow workers.

2:30 "The Recognition, Diagnosis, and Treatment of Breast Cancer"

FRANK E. ADAIR, M.D., New York, N. Y.

M.D., Johns Hopkins, 1915; Chairman, Committee for Treatment of Malignant Diseases, American College of Surgeons; Director, American Society for Control of Cancer; Attending Surgeon and Attending Officer, Memorial Hospital, New York; Consultant Surgeon, National Cancer Institute, Washington, D. C.; Consultant in Cancer, U. S. Veterans Administration; Consultant Surgeon, Hospital for Women and Children, Caledonian Hospital, New York; St. Luke's Hospital, Newburgh, N. Y., St. Joseph's Hospital.

A recent study made in New York state revealed that in 1933 750 patients with cancer of the skin, breast, mouth, rectum and uterus were studied; and of this number, 25.6 per cent had cancer which had not yet left its original site. Four years later, 1937, a group of 900 such cases were again studied, and they showed that 33.6 per cent had their disease still localized, demonstrating that in the same group 8 per cent more patients came early than did four years previously.

With the exception of skin cancer, there is probably no site where there should be such improvement in cures as in the breast.

3:00 INTERMISSION TO VIEW THE EXHIBITS

3:30 "Progress in Maternal Welfare"

JOSEPH LOUIS BAER, M.D., Chicago, Ill.

Professor of Obstetrics and Gynecology, Rush Medical College; Senior Attending Gynecologist and Attending Obstetrician, Michael Reese Hospital; Fellow, American Board of Obstetrics and Gynecology; Institute of Medicine, Chicago; American Gynecological Society, Board of Directors, Infant Welfare Society, Chicago.

There has long been need for better obstetric care of American women. Contrary opinion based on alleged statistical fallacies, comparisons between urban and rural data, institutional versus home deliveries, distinctions in population types, merely evades the issue. Facts about our national maternal welfare problem. Death rate in the registration area generally known. Disability rate largely ignored, a situation similar to the publicized results of auto accidents.

Prenatal care has improved. Deaths from toxemia have decreased. Deaths from sepsis and hemorrhage remain about stationary. Ignorance, poverty and lack of facilities are main factors. Improvement depends upon coöperation between the involved groups: (1) medical schools, hospitals, general practitioners and specialists; (2) the nursing profession; (3) all public agencies, community, state and federal; (4) an enlightened public.

4:00 "Field Studies in Scarlet Fever"

JOHN E. GORDON, M.D., Boston, Mass.

M.D., Rush Med. College, 1926; Military Service, Red Cross Commission on meningococcus



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meningitis; Commission of the Surgeon General, U. S. Army investigating influenza; Chief of Laboratories, Camp Gordon, Atlanta, Ga; Instructor in Bacteriology, U. of Chicago; Assoc. Prof. of Bact. U. of Western Ontario, Canada; Asst. Sup. of Municipal Contagious Disease Hospital, Chicago; Medical Director, Herman Kiefer Hospital, Detroit, 1927; Medical Epidemiologist, Detroit Dept. of Health, through 1934; Special instructor in Post-graduate Medicine, U. of Michigan; 1932, worked in Europe at Robert Koch Institute and Rudolf Virchow Krankenhaus, with particular interest in evaluation of European measures for isolation and quarantine; 1934, Field Director of the International Health Division Rockefeller Foundation—problems concerned with scarlet fever; Professor of Preventive Medicine and Epidemiology Harvard Medical School.

4:30 End of Fourth General Assembly.

### SAVE AN ORDER FOR THE M.S.M.S. EXHIBITORS

## WEDNESDAY EVENING September 21, 1938

### Fifth General Assembly

#### Public Meeting

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

HENRY COOK, M.D., Presiding  
L. FERNALD FOSTER, M.D., and WARD L. CHADWICK, M.D., Secretaries

### PRESIDENT'S NIGHT

#### P. M.

- 8:00 1. Call to order by the President
2. Invocation—Rev. Horace H. Mallinson, Detroit
3. Address of Welcome—Henry R. Carstens, M.D., Detroit, President, Wayne County Medical Society Response
4. Announcements and Reports of the House of Delegates
- 8:15 5. President's Annual Address—Henry Cook, M.D., Flint
6. Induction of Henry A. Luce, M.D., Detroit, into Office as President of the M.S.M.S.  
Presentation of Past President's Keys to Henry E. Perry, M.D., Newberry, Mich., and to Henry Cook, M.D., Flint, Mich.  
Responses
7. Resolutions and motions
8. Introduction of the President-Elect, and other new officers of the Michigan State Medical Society

- 8:45 9. The Andrew P. Biddle Oration:  
"Public Health the Product of Individual Preventive Medicine"

HAVEN EMERSON, M.D., New York, N. Y.

M.D., Columbia, 1899; Asst. in Medicine, Columbia, 1906-10; Commissioner of Health and President, Board of Health of the City of New York, 1915-17; Professor of Hygiene and Preventive Medicine, Cornell, 1919-20; Professor Public Health Administration and Director DeLamar Institute of Public Health, College of Physicians and Surgeons, Columbia, 1922; Survey of health and sanitation for League of Nations, Athens, Greece, 1929; National Advisory Health Council, 1931. Member, Committee of Expert Statisticians of League of Nations. Author of contributions in the fields of vital statistics, epidemiology, public health administration, and reports of surveys in a number of cities in this country for the city governments and volunteer health agencies.

The objectives sought by society through the agencies of government by the application of preventive medicine, have in most instances been previously attained for individuals and families by the independent services of the private practitioner.

The structure of modern local public health services is built upon the broad base of universal coöperation of the family physician, upon whose interest in the prevention as well as treatment of disease among his patients the health officer can always rely.

The more independent and encouraged by public authority is the practitioner of private medicine to engage in the prevention of disease in the individual and the family, the higher will be the level of community health and the more efficiently can public services be applied to supplement and assist him.

### Presentation of Biddle Oration Scroll to Doctor Emerson

10:00 End of Fifth General Assembly

## THURSDAY MORNING September 22, 1938

### Sixth General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

WILFRID HAUGHEY, M.D., Presiding  
L. FERNALD FOSTER, M.D., and RUTH HERRICK, M.D., Secretaries

#### A. M.

- 9:30 "The Application of Recent Advancements in Urinary Antisepsis to Private Practice"

HENRY F. HELMHOLZ, M.D., Rochester, Minn.

M.D., Johns Hopkins, 1921; Graduate work at Universities of Berlin, Breslau, and Vienna; Professor of Pediatrics, Graduate Medical School, U. of Minnesota; Head, Dept. of Pediatrics, Mayo Clinic; President, International Congress, of Pediatrics 1940; President American Academy of Pediatrics; Vice President, American Board of Pediatric Examiners; Past-president, American Pediatric Society.

#### Diagnosis:

- A. Determination of presence of infection.
- B. Determination of type of infection  
(1) By smear; (2) By cultures.
- C. Determination of kidney function.

# THURSDAY MORNING

## September 22, 1938

D. Determination of presence or absence of urinary stasis.

### Treatment:

- A. Indication for use of various urinary anti-septics according to:
  - (1) Infecting organism
  - (2) Renal function
  - (3) Reaction of urine.
- B. Dosage of antiseptic, and mode of administration.
- C. Culture control of urine.

### 10:00 "Clinical Nutritional Deficiency Disease"

RUSSELL L. HADEN, M.D., Cleveland, Ohio

*Johns Hopkins Medical School, 1915; Director of Laboratories, Henry Ford Hospital, Detroit, 1917-18 and 1919-21; Assistant Chief of Medical Service, Base Hospital, Camp Lee, Va., 1918-19; Professor of Experimental Medicine, University of Kansas, 1923-30; Head of Division of Medicine, Cleveland Clinic, since 1930; Member, Association of American Physicians, American Society of Clinical Investigation; American Association of Pathologists and Bacteriologists, American Clinical and Climatological Association, Central Society for Clinical Research.*

The lack of specific nutritional elements often leads to definite symptoms and clinical syndromes. Definite diseases such as scurvy, beri-beri and pellegra may occur. It is much more common, however, to have typical and milder symptoms as a result of the nutritional deficiency which are usually unrecognized. Often the deficiency is multiple, making the picture more complicated.

The important nutritional elements will be reviewed, their clinical importance evaluated and the results of a deficiency described. Typical case histories will be cited. The treatment will be emphasized.

### 10:30 INTERMISSION TO VIEW THE EXHIBITS

### 11:00 "Fractures about the Elbow Joint—to Cover All Bony Parts Entering Into the Joints"

"Fractures Around and In the Ankle Joint"

KELLOGG SPEED, M.D., Chicago, Ill.

*Rush Medical College 1904. Professor of Clinical Surgery, Rush Medical College; author of a standard text-book on fractures and dislocations; attending surgeon, Presbyterian Hospital, Chicago; Fellow, American Surgical Association, American Orthopedic Association, etc.; Chairman, Fracture Committee, A.M.A.*

The anatomy of and about the knee joint is briefly reviewed to illustrate the mechanism of injuries and to recall a mental picture to the surgeon during his examination of the patient. A list of the main symptoms of the principal injuries of the knee joint, exclusive of fracture, is given and the essential points and methods of the examination are enumerated. Specimen, films of conditions entering into differential diagnosis, a résumé of the author's findings in over 250 cases and the complications involving the internal structures of the joint are summarized.

### 11:30 "Federal and State Co-operation in Maternal and Child Health Services"

KATHARINE F. LENROOT, Washington, D. C.

*University of Wisconsin, 1912. Since 1914 with U. S. Children's Bureau, serving as assistant director until 1921, making studies of provision for dependent children and of methods of juvenile-court administration. In 1921 appointed Director, Editorial Division; 1922, Assistant Chief; appointed in 1934 as Chief of the Children's Bureau; Past President and now a member of the Executive Committee, National Conference of Social Work; member of the President's "Advisory Committee on Education."*

All the forty-eight states, Alaska, Hawaii, and the District of Columbia are coöperating with the Children's Bureau, through their State departments of health, in the extension and improve-

ment of maternal and child health services, and all the States but one are coöperating with the Bureau also in diagnostic treatment, and after-care services for crippled children. Under the program of Federal aid to the States authorized by the Social Security Act, the official State agencies, under plans developed in consultation with representatives of the medical profession and other interested groups, are bringing to mothers and children, especially in rural areas and small cities, expert medical advice and public health nursing, nutrition, dental health, school health, immunization, and health education service. Likewise State agencies entrusted with responsibility for services for the restoration of crippled children to lives of maximum usefulness and satisfaction are aided to develop a well-rounded program in which due attention is given to the physical and the social problems with which these children are confronted. Experience in Michigan under the crippled and afflicted children's acts affords an unusually broad field for analysis and demonstration of how public services for the medical care of children may best be organized.

### 12:00 "The Thyroid Gland and the Function of Reproduction"

ROBERT D. MUSSEY, M.D., Rochester, Minn.

*Professor of Obstetrics, Mayo Foundation Graduate School; Head of Section on Obstetrics, Mayo Clinic; Member, American Committee on Maternal Welfare.*

Hypothyroidism may be accompanied by disturbances of menstruation, decrease in fertility and abortion. In many instances improvement is obtained by elevation of the metabolic rate by carefully regulated doses of thyroid extract. Insufficient iodine in drinking water may be accompanied by the appearance of colloid goiter at the time of menses or during puberty, pregnancy or the menopause. The high incidence of colloid goiter in certain regions makes it particularly necessary to administer iodine as a prophylactic measure. Simple or hyperfunctioning adenomas or exophthalmic goiter may complicate pregnancy. The results of management of pregnancy and of the complicating thyroid disturbance is discussed.

### P. M.

### 12:30 End of Sixth General Assembly Luncheon

### A \$50,000 EXHIBIT ARRANGED FOR YOUR CONVENIENCE

## THURSDAY AFTERNOON

### September 22, 1938

### Seventh General Assembly

Grand Ballroom, Fourth Floor, Book-Cadillac Hotel

H. H. CUMMINGS, M.D., Presiding

L. FERNALD FOSTER, M.D., and E. R. WITWER, M.D., Secretaries

### P. M.

### 1:30 "Newer Methods in Neurological Diagnosis and Treatment"

ROY R. GRINKER, M.D., Chicago, Ill.

*Rush Medical College, 1921. Formerly Associate Professor of Neurology and Associate Professor of Psychiatry, University of Chicago; at present, Chairman of Department of Neuropsychiatry, Michael Reese Hospital; author of numerous scientific publications and the text "Neurology"; Associate Editor, Tice's "Practice of Medicine" for the neuropsychiatric section.*

The most important recent advance in neurological diagnosis has come from the method of electrical recording by means of radio amplification of action potentials or so-called brain waves from the surface of the intact human skull.



## THURSDAY AFTERNOON

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Diagnosis of various types psychoses, types of epilepsies and localization of brain tumors are possible by this method.

Other diagnostic means are associated with the effects of newer chemical therapy of certain metabolic disorders. Prostigmin has an extraordinary effect on myasthenia gravis and can be used as a means of differential diagnosis. Quinine has the same value in myotonia congenita. Ergotamine tartrate acts similarly both therapeutically and diagnostically in migraine.

The greatest recent advance therapeutically is the use of shock treatment for schizophrenia, using either insulin, in sufficient doses to produce coma, or metrazol, a camphor derivative, to produce convulsions. A high percentage of schizophrenics can be brought into remissions or complete recovery. The same methods have afforded some beneficial results in other psychoses. The above advances in diagnosis and treatment will be discussed as well as other minor matters.

## 2:00 "Recent Changes in the Teaching and Practice of Medicine"

FRED W. RANKIN, M.D., Lexington, Kentucky

*M.D., University of Maryland, 1909. Assistant Surgeon, St. Mary's Hospital, Mayo Clinic, 1916-23; Professor of Surgery, University of Louisville, 1922-23; Associate Professor Surgery, University of Minnesota Medical School, Mayo Foundation; Surgeon to Mayo Clinic, 1926-33; Surgeon to St. Joseph and Good Samaritan Hospitals, Lexington, Kentucky, since 1934; author of numerous papers on operative and clinical surgery; Major, Medical Corps, U.S.A.; Commanding officer, Base Hospital No. 26; Member, American Surgical Association, American Protologic Society (Hon.); Social Clinical Surgery, etc.*

## Practice of Medicine"

This subject deals with two main trends: First, toward specialization; and second, toward socialization. The specialization trend is obvious when one recalls the things that have happened in medical education, namely, the reduction of schools, the elevation of admission standards, and the establishment of definite post-graduate standards. The very fact that about one out of four men now practicing are limiting their work to specialties, is further evidence of this trend. Specialty boards and the other certifying bodies help to elevate the standards of surgery and its specialties likewise, and indicate that specialization is here to stay and probably will increase.

As to the second trend—socialization—I have an idea that that is being definitely fostered by purposeful groups both in state and Federal governments. Just what percentage of the medical profession desires a modified form of socialized medicine, I do not know, but I suspect that there is a small but definite group who would welcome it. Naturally, I approve of the policies of organized medicine which oppose vigorously socialized medicine, and believe in slow and orderly evolutionary changes which elevate standards of medical practice which insure adequate service to all groups.

## 2:30 "The Tuberculosis Program and the Practice of Medicine"

HORTON CASPARIS, M.D., Nashville, Tenn.

*Johns Hopkins Medical School, 1919. Children's Department, Johns Hopkins, 1920-24; Professor of Pediatrics, Vanderbilt University Medical School, 1925 to present; Member, Board of Directors, National Tuberculosis Association; President, Tennessee Tuberculosis Association.*

Tuberculosis is the most serious communicable disease we have. It is preventable and controllable, and the responsibility for this rests with the general medical profession rather than with the tuberculosis specialist. The specialist is for the purpose of helping us in general practice, rather

than shouldering the burden himself. If we apply the knowledge which is available concerning the control of tuberculosis, then the disease can be reduced to a minimal problem. But it is only through our constant every-day practical working vigilance such as we apply to other preventable diseases, that the above can be accomplished. An attempt will be made to outline practical methods which we can all use to lessen the burden of tuberculosis and get it under control.

## 3:00 INTERMISSION TO VIEW THE EXHIBITS

## 3:30 "The Conservative Treatment of Orthopaedic Conditions"

ALLEN FISKE VOSHELL, M.D., Baltimore, Md.

*Johns Hopkins, 1919. Professor, Orthopedic Surgery, University of Maryland; Director and Surgeon-in-Chief, Kernan Hospital for Crippled Children; Chief Visiting Orthopedist, Baltimore City Hospitals, University Hospital; Visiting Orthopedist, Mercy, Woman's, Union Memorial Hospitals; author of numerous publications on Orthopedics; Lt. Commander, Medical Reserve Corps, U. S. Navy, Fellow, American Academy of Orthopedic Surgeons; Member, Robert Jones Orthopedic Club, American Orthopedic Association, American Academy of Orthopedic Surgery.*

By the above title is meant the treatment of orthopedic conditions without considering operative procedures, except as incidental associations or as preliminary to the institution of after care. In other words, the text will not describe operations nor statistics developed upon operations per se. It is desired that a realization of the value of time, development, physical and occupational therapy, vocational training and mental education be implanted in the minds of the members of the medical profession. Too much stress and importance is now being placed upon surgery and not enough upon the really more important and permanently stable aspects of orthopedic treatment. Social welfare will be discussed from the standpoint of both the patient and his family, relative to the changes incident to prolonged hospitalization, etc.

A plea for a fully rounded and balanced program of care of the crippled will be made.

## 4:00 "Treatment of Common Diseases of the Skin"

HOWARD FOX, M.D., New York

*Professor of Dermatology and Syphilology, N. Y. U. College of Medicine; Visiting Dermatologist and Syphilologist-in-charge, Bellevue Hospital; Consulting Dermatologist to numerous hospitals (15) in metropolitan area; Member, Board of Directors and Former President, American Dermatological Association; President, American Board of Dermatology and Syphilology; President American Academy of Dermatology and Syphilology; Editor-in-Chief, Archives of Dermatology and Syphilology; Honorary or Corr. Member of ten foreign dermatological societies.*

Treatment mainly from the standpoint of personal experience: Acne, value of x-rays, failure of vaccine and hormonal therapy; Rhinophyma, scarification, desiccation, excision; Rhus dermatitis, desensitization; Bromoderma, saline injections; Herpes, small pox vaccine, snake venom; Zoster, pituitrin, iodides, paraffin spray for pain; Psoriasis, anthralin, coal tar (Goeckerman method); Lupus erythematosus, gold, bismuth, quinine, local use of gold; Pemphigus, failure of germanin; Sycosis, quinolor ointment; X-ray epilation vs. fractional doses; Lupus vulgaris, salt free diet; Papulo-necrotic tuberculide, antisiphilic treatment; Furunculosis, vaccines, toxoid; Impetigo, Alibour water, dyes; Erysipelas and chancroid, sulfanilimide; Verruca, curette, mercury internally, x-rays, suggestion; Epithelioma, radium, desiccation, Coutard method.

## 4:30 End of Seventh General Assembly and the Convention



## TECHNICAL EXHIBITS

**Akron Truss Company** Space No. 75  
**Detroit, Michigan**

Complete showing of Surgical Appliances including Akron Trusses, Belts, Surgical Corsets, Orthopedic Braces, Limbs, Hosiery, et cetera. Mr. Ed. W. Alexander, Manager, and Mrs. C. T. Roache, Surgical Fitter, will be on duty in Booth No. 75 to explain the new improvements of Akron Appliances. Twenty-three years' service to Michigan Physicians makes this the foremost exhibit of its kind.

**A. S. Aloe Company** Space No. 4  
**St. Louis, Missouri**

A. S. Aloe Company, in Space No. 4, will display a general line of surgical instruments, supplies and equipment for the physician and hospital. The Aloe Short Wave Diathermy, the DeBaKey Blood Transfusion Unit and many other specialties will be featured. The Michigan representative of the Aloe Company will supply those interested with brochures on Aloe Steeline, the most modern development in physician's fine treatment room furniture.

**Arlington Chemical Company** Space No. 15  
**Yonkers, New York**

The Arlington Chemical Company will feature their Biological and Pharmaceutical Products at the Michigan State Medical Society convention. A diagnostic protein outfit offered at \$9.75 consists of eighty of the most common factors in allergic conditions. Representatives in charge of the booth will be pleased to discuss any allergic problems.

**The Bard-Parker Company, Inc.** Space No. 7  
**Danbury, Connecticut**

Among the Bard-Parker products exhibited at booth No. 7 are Rib-Back Blades, Renewable Edge Scissors, stainless steel, Lahey Lock Forceps, Formaldehyde Germicide and Containers for rustproof sterilization of surgical instruments, and Hematological Case for obtaining blood samples at the bedside.

**Bilhuber-Knoll Corporation** Space No. 38  
**Jersey City, New Jersey**

Drugs you can use every day—Dilaudid hydrochloride for pain and cough relief; Theocalcin and Phyllein for purine medication in heart diseases; Metrazol for stimulation in the emergency; and your old friends, Euresol and Bromural, can be discussed with well-informed representatives at this exhibit.

**Burroughs-Wellcome & Company** Space No. 12  
**New York, New York**

The Burroughs-Wellcome & Company exhibit at Booth No. 12 presents a wide range of new and important advances in pharmacological and chemical research.

**S. H. Camp & Company** Space No. 22  
**Jackson, Michigan**

You are cordially invited to visit Booth No. 22 where S. H. Camp & Company, manufacturers of scientific supports, will have representatives to instruct you in the latest developments of Camp Supports, show you samples and fully explain their use and application. Supports are constantly being improved to meet changing needs and these improved phases will interest you.

**Coca-Cola Company** Space No. 70  
**Atlanta, Georgia**

Coca-Cola will be served to the physicians with the compliments of the Coca-Cola Company.

**Cottrell-Clarke, Inc.** Space No. 64  
**Detroit, Michigan**

A real surprise awaits the doctor who has failed to keep in intimate touch with Michigan's own case record house, Cottrell-Clarke, Inc., Detroit. At their exhibit will be shown every form of case record, from those especially devised for the urban practitioner to their latest scientific developments for the big city specialist, clinics and hospitals.

**R. B. Davis Company** Space No. 66  
**Hoboken, New Jersey**

Enjoy a drink of delicious Cocomalt at Booth No. 66. Cocomalt is refreshing, nourishing and of the highest quality. It has a rich content of Vitamin D, Calcium and Phosphorus to aid the development of strong bones and sound teeth; Iron for the blood; Protein for strength and muscle; Carbohydrate for energy.

**Detroit X-Ray Sales Company** Space No. 59  
**Detroit, Michigan**

This Company again takes pleasure in presenting to the Profession the products of the F. Mattern Manufacturing Company of Chicago, and extends a cordial invitation to visit our booth and inspect a radically new design of Shockproof X-Ray Machine attractively priced. Be sure to stop at Booth No. 59.

**Dictaphone Sales Corporation** Space No. 71  
**Detroit, Michigan**

The Dictaphone Sales Corporation cordially invites you to inspect its display of Dictaphone equipment in Space No. 71, and to discuss its application in the medical profession with those in attendance. Dictaphone Dictating machines with Nuphonic recording, Transcribing machines with Nuphonic reproduction, together with S-12 Shaving machines will be on demonstration.

**Duke Laboratories, Inc.** Space No. 52  
**Long Island City, New York**

At Booth No. 52, the Duke Laboratories, Inc., will demonstrate the original, American-made, stretchable, adhesive-surfaced bandage, Elastoplast, approved by the American College of Surgeons. Elastoplast is used whenever compression and support are required, and is rapidly taking the place of the Unna Boot in the treatment of varicose ulcers. Samples of Medioplast, the Elastoplast speed compress used in the treatment of minor injuries may be had, also samples of Nivea and Basis Soap—the prescriber's cosmetics.

**Electray Equipment Company** Space No. 33  
**Detroit, Michigan**

We will show the Peerless Laboratories products, featuring a new model six meter ultra short wave, which is designed to produce maximum power output with low power consumption and especially the ability to heat low resistance tissue. Other Peerless products include a new sine and galvanic generator operated with vacuum tubes minus motor and rotating parts and their new x-ray equipment now manufactured in the same factory.

**General Electric X-Ray Corporation** Space No. 53  
**Chicago, Illinois**

It is the policy of the General Electric X-Ray Corporation to try, at each meeting of the Michigan State Medical Society, to have an interesting exhibit for the visiting doctor. All we ask is that he pay us a visit and meet our representatives who are very helpful in the matter of x-ray and physical therapy problems.

**Gerber Products Company** Space No. 45  
**Fremont, Michigan**

Gerber's, manufacturers of strained foods, in Booth No. 45, cordially invite you to inspect the strained foods on display. Two kinds of literature are available for examination and will be sent to you, on request. Part of this literature is for professional use only, but the booklets are available for distribution to mothers or adult patients on therapeutic diets.

**Gordon Shoe Company** Space No. 72  
**Detroit, Michigan**

Shoe Prescriptionists for twenty-two years in providing foot comfort to men, women and children. The Gordon Shoe Company has an established reputation for carrying out "Doctor's orders." You will enjoy a visit to their display and the opportunity to view a distinct and comprehensive exhibit of their famous Ground Grip-Per Footwear.

**Hack Shoe Company** Space No. 3  
**Detroit, Michigan**

The first display to greet your eye when you step off the elevator will be that of Detroit's internationally known "Home of Shoe Prescriptions." Hack will exhibit HACK STABILIZER SHOES for men, women and children; Arch Supportive Gym Shoes for children; Tennis and Basketball shoes for men; Operating Room shoes; Hack-O-Pedic Clubfoot and Surgical Shoes.

**Hanovia Chemical & Manufacturing Company** Spaces No. 5 & 6  
**Newark, New Jersey**

A complete line of ultraviolet quartz lamps, Sollux Radiant Heat Lamps and Short Wave Therapy Units will be on display. Don't fail to see the new innovation, the Super "S" Alpine Sun Lamp. It lights automatically and has ten steps of intensity regulation.



Courteous representatives will be present to welcome you.

**J. F. Hartz Company** **Space No. 54**  
**Detroit, Michigan**

The J. F. Hartz Company will display the latest and most modern in equipment and apparatus at the September Convention. Especial attention will be given to the new Surgical Instruments. Physiotherapy equipment will also be a prominent feature of the display, and competent, well-informed attendants will be on hand to demonstrate.

**H. J. Heinz Company** **Space No. 43**  
**Pittsburgh, Pennsylvania**

In order that you may see the natural fresh color and uniform consistency of Heinz Strained Foods, our display presents, in an attractive manner, all twelve varieties. Naturally, you have some questions as to their preparation and uses. We, therefore, invite you to let our representative serve you in this respect. We will be glad to send you a copy of the fifth edition of our Nutritional Chart, upon registration at our exhibit.

**Holland-Rantos, Inc.** **Space No. 36**  
**New York, New York**

Several new products in the field of contraception will be displayed at the Holland-Rantos booth. These in addition to the already well known Koromex diaphragm and Koromex Jelly. The new products are: H-R Emulsion Jelly, the new Koromex Diaphragm Introductor and the Bach Pessalator Set.

**Horlick's Malted Milk Corporation** **Space No. 28**  
**Racine, Wisconsin**

Nourishing, digestible, appetizing—these are three outstanding qualities for which Horlick's is famous, either the powdered or tablet form. Visit Booth No. 28. You will be interested in the many uses—from infant feeding to old age—note especially the convenience of the tablets, for interval feeding in ulcer diets.

**The G. A. Ingram Company** **Spaces No. 62 & 63**  
**Detroit, Michigan**

The G. A. Ingram Company will exhibit the new Electrocardiograph designed by Charles Hindle and manufactured by the Beck-Lee Corporation. In addition, their exhibit will include the latest physio-therapy equipment, examining room furniture, surgical instruments, and many other specialties that will be of interest to the profession. They will consider it an honor if you will stop and look over their exhibit.

**Jones Metabolism Equipment Company** **Space No. 8**  
**Chicago, Illinois**

The Jones Metabolism Equipment Company will feature as their display the Jones Motor Basal metabolism apparatus. A special feature of this unit is that it contains no water and requires no calculation in the determination of the basal metabolic rate.

**Jones Surgical Supply Company** **Space No. 56**  
**Cleveland, Ohio**

The Jones Surgical Supply Company will exhibit a complete line of surgical instruments, and sundries, short wave diathermy, suction and pressure units, along with numerous specialty items.

**A. Kuhlman & Company** **Space No. 69**  
**Detroit, Michigan**

A. Kuhlman and Company will show a line of Allison professional furniture, a new high power, low price suction and ether pump, an improved short wave generator. Miller Abbott tube for intestinal intubation, a line of latex urethral and retaining catheters, a new portable air purifying and odor destroying generator.

**Lea & Febiger** **Space No. 55**  
**Philadelphia, Pennsylvania**

Lea & Febiger will exhibit the following new works—Pohle's "Theoretical Principles of Roentgen Therapy and Clinical Roentgen Therapy"; Brenner's "Pediatric Surgery"; Perkins' "Cause and Prevention of Disease"; Steel's "Biological and Clinical Chemistry"; Weinzirl's "Hygiene"; Craig & Faust's "Clinical Parasitology"; Fishberg's "Heart Failure"; Davidoff & Dyke's "Normal Encephalogram"; Rowe's "Clinical Allergy"; Saxl's "Pediatric Dietetics," and others.

**Lederle Laboratories, Inc.** **Space No. 25**  
**New York, New York**

Lederle Laboratories, Inc., will feature a sea-

sonal display of therapeutic sera for all types of pneumococcus pneumonia, Globulin Modified Lederle Antitoxins; Oral and Parenteral Liver, Pergussis Antigen, Diphtheria Toxoid and the Vitamin Products, including Vi-Delga Emulsion (also available in capsule form), and Vitamin B Complex. Literature on all products will be available, as well as samples of the two vitamin products mentioned.

**Libby, McNeill & Libby** **Space No. 68**  
**Chicago, Illinois**

Libby, McNeill & Libby extend a cordial invitation to all physicians to visit the Libby booth and enjoy samples of Libby's fruit julees. The many advantages of Libby's Homogenized Baby Foods, which make babies' vegetables easier to digest than the finest straining or sieving, are graphically presented. You may register for samples and literature of these baby foods.

**Liebel-Flarsheim Company** **Space No. 50**  
**Cincinnati, Ohio**

Liebel-Flarsheim will exhibit the well-known L-F Short Wave Generators, as well as the famous Bovie Electro-Surgical Units. In addition, other new and useful physiotherapy apparatus will be shown. A cordial invitation is extended to visit the Liebel-Flarsheim booth No. 50 and have this apparatus demonstrated to you.

**J. B. Lippincott Company** **Space No. 9**  
**Philadelphia, Pennsylvania**

J. B. Lippincott Company will display NEW books: Bacon—Anus, Rectum and Sigmoid Colon; Thorek—Modern Surgical Technique; Kracke—Diseases of the Blood and Atlas of Hematology; Wilson—Fractures; Wolf—Physician's Business . . . and New Editions of old favorites: McBride—Disability Evaluation; Rehberger—Quick Reference Book of Medicine and Surgery; Thorek—Surgical Errors and Safeguards; and Means—Thyroid and Its Diseases. See also the NEW International Clinics edited by Dr. George Morris Piersol.

**M & R Dietetic Laboratories, Inc.** **Space No. 47**  
**Columbus, Ohio**

M & R Dietetic Laboratories, Inc., will display Similac and powdered SofKurd. Representatives will be glad to discuss the merits and suggested application of these products.

**Mead Johnson & Company** **Spaces No. 29 & 30**  
**Evansville, Indiana**

Mead Johnson & Company are distributing, this year an unusually fine souvenir item. It is not only beautiful but extraordinary because it contains no advertising. Ask for your copy of "Parergon." The complete display of Mead Products includes two new ones.

**Medical Arts Surgical Supply Company** **Spaces No. 26 & 27**  
**Grand Rapids, Michigan**

The Medical Arts Surgical Supply Company will feature a complete line of Hamilton medical furniture which includes the very attractive Nu Classic & Hometone suites. They will also show Physiotherapy equipment by Liebel-Flarsheim, stainless steel instruments, rotary compressors, sterilizing and autoclave equipment, and other items.

**Medical Case History Bureau** **Space No. 40**  
**New York, New York**

Inexpensive Case History Method. A system that shows at a glance the case you want, how many calls you made and when, the patient's history, the developments, diagnosis and treatments, as well as the financial status of each case, is shown in Booth No. 40 by the Medical Case History Bureau. All the history forms are displayed as they are actually kept in their cabinets.

**Medical Protective Company** **Space No. 39**  
**Wheaton, Illinois**

Ask the Medical Protective Company's representative to explain how his company meets the exacting requirements of adequate liability protection, which are peculiar to the Professional Liability field.

**The Mennen Company** **Space No. 48**  
**Newark, New Jersey**

The Mennen Company will exhibit their two famous baby products, Antiseptic Oil and Antiseptic Borated Powder. Included in the exhibit will be their complete line of shaving and after-



shave products for men. Be sure to register at the Mennen exhibit to receive your kit of samples, and participate in the prize drawing for Fitted Leather Toilet Kits.

**Merck & Company, Inc. Spaces No. 10 & 11  
Rahway, New Jersey**

Vitamin C, an essential dietary constituent, will be the featured display at the Merck booth. Individuals who are on a restricted diet frequently require a supplemental quantity of vitamin C. To be positive that they obtain the necessary amount and to be assured that the benefit of accurate dosage is derived, vitamin C is best prescribed in the form of Cebione. Cebione is the only vitamin C available that is Council accepted. For information regarding Cebione, please register at the Merck Booth, No. 10 and 11.

**The Wm. S. Merrell Company Space No. 46  
Cincinnati, Ohio**

A number of new and interesting therapeutic agents are on display at the exhibit of The Wm. S. Merrell Company at booth number 46. Representatives in attendance will courteously show and explain any Merrell preparation of interest to visitors. Soricin, Diothane Hydrochloride, Natural Salicylates, Fibrogen and many other familiar time-tried Merrell products are also being shown.

**The C. V. Mosby Company Space No. 2  
St. Louis, Missouri**

Among the many new books to be exhibited by the C. V. Mosby Company are: Jensen's "The Heart in Pregnancy"; the Fifth Edition of Porter and Carter's "Management of the Sick Infant and Child"; Pottenger's "Symptoms of Visceral Disease"; Pruitt's "Hemorrhoids"; Watson's "Hernia"; Rea's "Neuro-Ophthalmology"; the Fifth Edition of Crossen's "Operative Gynecology," and the Sixth Edition of Clendening's "Methods of Treatment." Approximately one hundred other volumes will complete the exhibit.

**Nestle's Milk Products Company Space No. 16  
New York, New York**

Nestle's Milk Products, Inc., in Space No. 16, are exhibiting an original oil painting as the main feature of their display. The painting represents a nursery scene and is the work of Stephen Csoka, who executed the canvas especially for Nestle.

**Parke, Davis & Company  
Detroit, Michigan Spaces No. 17-18-19-20**

A number of scientific accomplishments will be displayed by Parke, Davis & Company's staff of expert technical men in charge of Booths No. 17, 18, 19 and 20. Products of special interest to the medical profession will be shown, including Mapharsen (an advance in antisyphilitic therapy), glandular products (Theelin, Adrenalin and the Pituitrin group); also Meningococcus Antitoxin, and other biological products.

**Pelton & Crane Company Spaces No. 57 & 58  
Detroit, Michigan**

The Pelton and Crane Company will exhibit the new 25-Point Pelton Sterilizers featuring 3-speed or Super-Automatic Models both with the famous Pelton "Sentry" Cutoff, self-draining cast-bronze boiler, enclosed type heater, and many other exclusive features. Also on exhibit will be the new Pelton Utility Light and the Pelton Super-Sterilizer for correct pressure sterilization in the private office, as well as representative models of the complete Pelton line of surgical Cuspidors.

**Pet Milk Company Spaces No. 41 & 42  
St. Louis, Missouri**

An actual working model of a milk condensing plant in miniature will be exhibited by the Pet Milk Company in booths numbers 41 and 42. This exhibit offers an opportunity to obtain information about the production of Irradiated Pet Milk and its uses in infant feeding and general dietary practice. Miniature Pet Milk cans will be given to each physician who visits the Pet Milk Booth.

**Petrolagar Laboratories, Inc. Space No. 67  
Chicago, Illinois**

Physicians are cordially invited to visit the new convention display at Booth No. 67 where Petrolagar Laboratories, Inc., will be represented by Messrs. R. J. Corkery and L. F. Harrison. New literature, samples and information regarding Petrolagar will be available.

**Philip Morris & Co., Ltd. Space No. 21  
New York, New York**

Philip Morris & Co. Ltd., Inc., will demonstrate the method by which it was found that Philip Morris cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches and problems on the physiological effects of smoking.

**Physicians Equipment Exchange Space No. 73  
Detroit, Michigan**

Renewed medical equipment will be exhibited at Booth No. 73. Something entirely new in medical equipment for your close inspection. Used, but indistinguishable from new. Completely re-enameled and re-finished with a new furniture guarantee. (Ask the doctor who has bought our renewed medical equipment). Save half your cost.

**Picker X-Ray Corporation Space No. 23  
Detroit, Michigan**

The very latest in a moderate priced Radiographic and Fluoroscopic shock proof and ray proof tilt table, containing all the features of an X-ray and Fluoroscopic plant. Radiographic and Fluoroscopic accessories of proven merit, such as Keraphen, Basolac, etc.

**Pocahontas Fuel Company Space No. 74  
Detroit, Michigan**

A demonstration of Heating with Coal for Health's sake by the "O.P." completely Automatic Stoker.

Dustless coal fed from bin to furnace thoroughly burned and ash completely removed to dust-proof cans with no clinker formation. This maintains circulation of air at even temperature, the two salient requirements of body comfort and health.

Doctors, discuss your heating problems with our heating engineers.

**Professional Management Space No. 65  
Battle Creek, Michigan**

"A Complete Business Service to the Medical Profession."

Discussing office procedures, supervision of collections, and office management; showing samples of efficient office records; distributing reprints from the Michigan State Medical Journal on "The Business Side of Medicine."

**Randolph Surgical Supply Company  
Detroit, Michigan Spaces No. 13 & 14**

A 1939 medical furniture fair will be presented to Michigan physicians by the Randolph Surgical Supply Company. Whether or not you need new equipment, this exhibit will be worth your inspection. A varied assembly of the newest Hamilton examining tables, cabinets, et cetera, embodying advanced features of efficiency and design will be shown. Diagnostic instruments, surgical supplies, short wave and electrical equipment will be included in the display.

**Sandoz Chemical Works, Inc. Space No. 24  
New York, New York**

"Gynergen" (Ergotamine Tartrate) for the dramatic relief of migraine; "Calglucon" (Calcium-gluconate) in granules, effervescent and chocolate flavored tablets; "Neo-Calglucon" for parenteral administration; "Scillaren" and "Scillaren-B," the cardioactive principles of squill; "Digilamid," crystallized initial glucosides of digitalis lanta; the neurovegetative sedatives, Belladonal, Bellergal and Calcibronat; Basergin and Neo-Gynergen for obstetrical use.

**W. B. Saunders Company Space No. 49  
Philadelphia, Pennsylvania**

W. B. Saunders Company will exhibit a complete line of their books for the medical, dental, nursing and allied professions. Included in the many new books and new editions will be a brand new edition of Beckman's "Treatment," Herman's new "Urology," Buie's "Practical Proctology," Max Cutler's new Cancer book, Barsky's new "Plastic Surgery," as well as many other editions.

**Smith, Kline & French Laboratories Spaces  
Philadelphia, Pennsylvania No. 34 & 35**

Smith, Kline & French Laboratories will distribute samples of "Benzedrine Inhaler," their Volatile vasoconstrictor. Another form of ban-



zyl methyl earbinamine S.K.F. will also be shown—"Benzedrine Solution"; as well as Pent-nucleotide, for agranulocytosis.

**E. R. Squibb & Sons** **Space No. 44**  
**New York, New York**

Physicians attending the Michigan State Medical Society Convention are cordially invited to visit the Squibb exhibit. The complete line of Squibb Glandular, Vitamin, Arsenical and Biological Products and Specialties, as well as a number of interesting new items will be featured. Well informed Squibb representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

**Frederick Stearns & Company**  
**Detroit, Michigan** **Spaces No. 60 & 61**

Doctors are invited to visit our booth where various outstanding contributions to medical science will be exhibited in a beautiful new modern display. Information on such outstanding products as Neo-Synephrin Sterile Solution for parenteral use in acute hypotension; Appella Apple Powder for infantile diarrheas; Trimax, Hydrated Magnesium Trisilicate; Insulin-Stearns; and other new and interesting products will be supplied by Stearns' capable representatives.

**Van Hoosen Farms** **Space No. 37**  
**Rochester, Michigan**

Our display will emphasize three points: (a) The cleanliness and nutritive value of certified milk. (b) The production and importance of Metabolized Vitamin D Milk. (c) The high Vitamin A content of Holstein milk.

**James Vernor Company** **Space No. 1**  
**Detroit, Michigan**

Vernor's Ginger Ale needs no introduction in medical circles. Its manifold uses are familiar to dietitian and surgeon alike. The dry ice dispenser shown at Booth No. 1 at the M.S.M.S. Annual Convention and Exhibition with an appropriate display of Vernor's products, is the latest development for party uses. This unit is designed to serve a cold, tangy glass of Vernor's with all the efficiency of a fountain. Our hostess will be pleased to arrange for this service with a neat booth or stand, as you may desire.

**Wall Chemicals, Inc.** **Space No. 31**  
**Detroit, Michigan**

A display of all types of medical gas cylinders and equipment and their different uses in conjunction with gas-ether anesthesia machines and oxygen tents, et cetera. Complete disassembled valves will also be on exhibit, in order that the medical gas users will be able to gain a better conception of their structure.

**John Wyeth & Brother, Inc.** **Space No. 32**  
**Philadelphia, Pennsylvania**

Booth No. 32, John Wyeth & Brother, Philadelphia, will feature Silver Picrate in the treatment of Trichomonas Vaginalis Vaginitis. The use of Silver Picrate in the treatment of Trichomonas Vaginitis is extremely simple, consisting of two insufflations of the Powder and supplemental use of Silver Picrate Suppositories. Silver Picrate, Wyeth, is also available in crystalline form for the preparation of fresh solution. Physicians are cordially invited to stop at the Wyeth Booth and receive full information concerning Silver Picrate and its use in Trichomonas Vaginalis Vaginitis.

**The Zemmer Company** **Space No. 51**  
**Pittsburgh, Pennsylvania**

The Zemmer Company, Pittsburgh, Pennsylvania, manufacturers of a complete line of ethical pharmaceuticals, will occupy Space No. 51 at the 1938 Detroit Convention of the Michigan State Medical Society next September. A cordial invitation is extended to members of the medical profession to visit Exhibit Space No. 51.

**The Zimmer Manufacturing Company**  
**Warsaw, Indiana** **Space No. 76**

The Zimmer Manufacturing Company will exhibit a complete line of fracture appliances. Among some of the new items of special interest are Smith-Petersen Nail accessories, Goniometers, Orthopedic Wrenches, Wangenstein Aspirators, New Types of Orthopedic Braces, et cetera. Mr. C. A. Fisher will be in charge of the booth.

**ANNUAL REPORT OF THE COUNCIL, M.S.M.S., 1937-38**

Since the 1937 session of the House of Delegates, the Council has convened four times (up to Sept. 19, 1938) and the Executive Committee eight times—a total of twelve meetings. As in the past, all M.S.M.S. officers were invited to meetings of the Executive Committee, and the minutes of its transactions were mailed to all councilors and officers, as well as published in THE JOURNAL. The matters studied by the 23 committees of the M.S.M.S. were routinely referred to The Council or its Executive Committee, for consideration and approval; in the main, the chairmen of these committees were invited to be present at the monthly meetings of the Executive Committee. The large attendance at these sessions testified to the intense interest of an increasing group of members who are working in behalf of the Michigan State Medical Society.

**Membership**

Members in good standing as of December 31, 1937, totalled 3,963, a gain of 238 over the preceding year. The membership as of July 31, 1938, totalled 3,958, compared with 3,757 as of the same date in 1937. The membership will be increased by the time of the Annual Meeting in September.

Despite the "rescession" of 1938, the increased activities of the State Society and a resulting appreciation of the benefits of membership, interested a good number of physicians to affiliate as new members of organized medicine, and also helped to sustain the regular membership total to a very satisfactory figure. We are sure the members feel they are deriving benefits from their investment.

Your Council considered a change in the Constitution (Article Three, Section One), to insure that active membership in a county medical society shall include active membership in the State Society, and respectfully recommends to the House of Delegates that the present Section be amended by adding, after the words "have been paid," the following sentence: "Membership in a County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized."

**Finances**

The auditor's report, containing the financial statement of the Society for 1937, was printed in THE JOURNAL (Feb., 1938, pages 173-4-5).

During the year past, detailed reports on the financial condition of the Society were presented monthly to the Executive Committee of The Council; also analyses of the budget versus actual expenditures were made periodically.

A special committee on securities was appointed to present quotations on the M.S.M.S. bonds and the valuation of same, at meetings of the Executive Committee.

While it is difficult to ascertain how the current year will come out from the financial standpoint, your Council believes that it will be several thousand dollars in the black at the end of December, 1938, despite the payment this year of a \$3,500.00 debt carried over from 1937 operations. This favorable condition is in the face of an extension in 1938 of many activities in behalf of practitioners and of the public.

**Journal**

At the beginning of 1938, your Council prophesied a sharp decline in JOURNAL advertising revenue, because of the times. In the main, this has not been realized to date, due to increased activity in the Executive Office which has not only maintained



steady promotion with advertisers and prospective advertisers, but has mailed hundreds of letters to the membership, to stimulate greater reader-interest.

THE JOURNAL has been limited to 100 pages per issue, to keep down expense. The quality of the scientific articles is as high as ever; the interest in the Society Activity Department has been increased by new innovation and personalizing. The special souvenir editions (the Directory Number in May and the Convention Number in September) have been continued, resulting in increased revenue.

The Council recommends an increase in the use of professional cards in THE JOURNAL.

The Council aims to keep the membership thoroughly informed concerning every activity of the State Society through the columns of the JOURNAL.

#### Contacts With Governmental Agencies

The outstanding feature of the Michigan State Medical Society's activity during the past year has been the extraordinary increase in contacts with agencies of government, including the Board of Labor and Industry, the Attorney General, the Auditor General, the Michigan Crippled Children Commission, the Michigan Department of Corrections and Parole, the Welfare Department, the Civil Service Commission, the Department of Public Instruction, the State Hospital Commission, the Department of Drugs and Drug-stores, the Old Age Pension Bureau, the State Accident Fund, the State Insurance Department, the Governor's Survey Committee, the State Board of Registration in Medicine, and the State Department of Health. In the main, these contacts have been two-fold: the various state departments have called upon the Michigan State Medical Society for technical advice and counsel; the State Society has presented to governmental agencies the problems of individual physicians and of the State Society as a whole, for solution.

The Labor Board sought help in the administration of the Occupational Disease Law.

The Attorney General (through the State Board of Registration in Medicine) requested the State Society to write a booklet on the "evils of marihuana." The State Society sought a modification of the Attorney General's opinion on "x-ray interpretation."

Numerous meetings were held with the Auditor General and with the Crippled Children Commission relative to problems associated with the Afflicted-Crippled Child Laws; it is gratifying that on June 1, 1938, a final settlement of the problem of certain specialists in connection with these laws was made, in that in future, radiologists, pathologists and anesthetists are recognized as practitioners of medicine, and are placed in Schedules A and C. In addition, the Crippled Children Commission called upon the State Society to develop a brochure on "Treatment of Burns."

The Department of Corrections and Parole called upon the State Society for technical assistance re medical service in penal institutions.

Numerous contacts were made with the Welfare Department re medical care of the indigent, the WPA employee, and the possibility of a rehabilitation program in Michigan.

Contact was made with the Civil Service Commission, with the Parole Board, and with the State Hospital Commission re complaint that physicians in state institutions would be required, under the Civil Service Commission regulations, to furnish care to state employees, who would receive payment in kind, other than cash salaries.

The Department of Public Instruction sought help from the State Society re problems of the unusual child.

The Department of Drugs and Drugstores was contacted frequently re the State Narcotic Law and the special fee imposed upon physicians.

The Old Age Pension Bureau was visited frequently re some plan whereby recipients of Old Age benefits could obtain necessary medical care from their family physicians.

The Governor's Medical Survey Committee, created to aid the state and county medical societies with a portion of the A.M.A. Survey, held meetings with M.S.M.S. representatives on three occasions.

Through a coöperative arrangement of the State Department of Health and the State Board of Registration in Medicine, an inspector was appointed during the past year to investigate violations of the Medical Practice Act. The contact of the State Society with these two governmental agencies in all matters has been frequent and most cordial.

The State Accident Fund sought the help of the State Society with problems of so-called medical care by irregulars.

The State Insurance Commissioner was seen frequently regarding the activities of cultists, and the organization of commercial concerns offering group hospitalization.

#### Contacts With Unofficial Groups

Friendship with other groups interested in medical services was strengthened during the past year: with the Michigan State Dental Society, which now has a full-time Executive Secretary in Lansing; with the pharmaceutical group, with whom relations have been very harmonious; with the State Bar of Michigan, which sought the help of the M.S.M.S. with its Supreme Court Amendment. Other groups contacted during the year included the Michigan Conference of Social Work, the newly-formed Michigan Health League, the Michigan State Board of Registration of Nurses, which met with a committee appointed by the Council to study (in compliance with instructions of the House of Delegates) the requirements for Nurses Training Schools; this committee held several meetings with the State Board of Nurses but failed to secure a wholesome coöperation from its representatives, and the objectives were not realized.

"Group Hospitalization" was discussed with representatives of the Michigan Hospital Association at several conferences, but no agreement was reached.

An endeavor to secure liens for physicians in accident and health cases is being negotiated with insurance companies, in order to obtain this result by arbitration rather than attempt to seek approval from the Legislature.

Other contacts were made with the health officers at their annual June conference, with the Michigan Public Health Association at its November meeting, and with representatives of sixteen state medical societies at the Northwest Conference in Chicago in February, on which occasion your M.S.M.S. Secretary was elected Secretary of the Conference, which honor to Michigan carries with it the obligation of being Conference Host in 1940.

#### Organization

The 1936 House of Delegates made it mandatory that the officers of the Michigan State Medical Society visit all county medical societies once a year.

This order has been obeyed in 1937-38, with visitations by your President, or Secretary, members of The Council, members of the Public Re-



lations Committee or the Executive Secretary. This travel has been done not without great personal sacrifice on the part of your State Society officers—the hours going to, attending, and returning from meetings representing an aggregate of approximately two months away from their offices.

The A.M.A. Survey required much additional work and travel this year, the officers and Public Relations Committee members being specifically invited by county medical societies to visit them and explain the details of this monumental work. The U. P. Secretaries' Conference of May 15 in Marquette was a case in point. It is apparent that county societies are looking more and more to the Michigan State Medical Society for guidance and counsel; in addition, individual councilors requested visitations by M.S.M.S. officers, to help solve acute problems in their districts. During the past year, it was necessary to contact several inactive county medical societies and awaken them to their responsibilities and opportunities.

Your State Society officers attended 25 "State Society Nights" arranged by county medical societies; in addition, they accepted frequent invitations to address county units during the past year.

It is anticipated that as much, if not more, travel will be pressed upon the Councilors, officers and the Executive Secretary of the State Society during the ensuing 12 months, if good organization throughout the 83 counties is to be maintained.

The Council feels that any extra travel expense of the past two years has been more than offset by greater activity of the county units reflected in a keener coöperation in such important activities as legislation, postgraduate medical education, and socio-economic matters; it has resulted in an apparent appreciation by county medical societies of the State Society's efforts to assist them with their acute problems. Moreover, the individual members of the M.S.M.S. gain a personal acquaintanceship with the State Society officers—get to know them in the flesh and have an opportunity to present their own problems to them face to face, at a round-table discussion—with the result that more members seem to have added confidence in the Michigan State Medical Society and greater satisfaction and pride in their association with the organization.

The Council recommends the continuation of two secretaries' conferences each year, one on the occasion of the annual meeting, and the other in mid-winter. It feels that the innovation of the Secretaries' Conference of the U. P. societies was worth while.

Your Council recommends the merger of the Delta and Schoolcraft county medical societies; also the partition of the present 13th Councilor District, as requested by the county medical societies comprising same, and the re-numbering of the 17th Councilor District in the Upper Peninsula, to the "13th District."

The Council reiterates its oft-repeated recommendation that county medical societies retain efficient secretaries and delegates.

### County Societies

More county societies have elicited greater activity this year than ever was apparent in the history of the Michigan State Medical Society. Approximately 12 county units have instituted outstanding programs which merit commendation, and emulation by other county medical societies. An example of this is the Ingham County Society's "Syphilis Control Program" which was presented

to the M.S.M.S. for approval, and subsequently was given coöperation by the U. S. Public Health Service.

The Secretary's Letters were sent monthly to county society presidents, secretaries and delegates; and four times during the year to all members of the M.S.M.S.

*The Medical History of Michigan* was presented to physicians who attended the January Secretaries' Conference, for distribution to local public, medical, and hospital libraries of the state.

The scientific programs of most county medical societies were well worth while; some of the smaller societies were assisted in securing speakers through the M.S.M.S. It is again recommended that county societies give time on their programs for organizational and socio-economic discussions. We feel that every society should be visited by some of the State Society officers at least once a year.

### Committees

To best appreciate the volume of work done by the State Society, we have but to look at the accompanying analysis of meetings of the Council and its Executive Committee, and the twenty-three other committees of the M.S.M.S.

### COUNCIL AND COMMITTEE MEETINGS

1937-1938

Committee	Date	City	Number Meetings
Council .....	9/28 1/12-13 8/3	Grand Rapids Detroit Pt. L.	3
Executive Committee of Council.....	10/17 11/10 12/12 2/9 3/13 4/14 5/18 6/30	Detroit Detroit Detroit Grand Rapids Detroit Lansing Eloise Washington Co.	8
Legislative .....	11/10 2/27 3/30 5/24 7/28 8/14	Detroit Lansing Flint Detroit Detroit Lansing	6
Joint Comm. on Health Education.	6/22	Ann Arbor	1
Dist. of Medical Care.....	12/8 1/12 6/12	Detroit Lansing Lansing	3
Cancer .....	9/28 11/26 12/12 3/12 5/28	Grand Rapids Ann Arbor Ann Arbor Detroit Ann Arbor	5
Preventive Medicine .....	9/29 11/14 1/19 5/22	Grand Rapids Lansing Flint Detroit	4
Syphilis Control—Subcommittee....	9/30 11/14 1/9 5/22	Grand Rapids Lansing Flint Detroit	4
T. B. Control—Subcommittee.....	11/14 11/26 1/7 5/20	Lansing Lansing Lansing Lansing	4
Woman's Auxiliary.....	11/17 5/5	Lansing Lansing	2
Radio .....	No meeting; work done in collaboration with Joint Committee on Health Education		
P. G. Medical Education.....	12/16 4/20	Detroit Detroit	2

# ANNUAL REPORT OF THE COUNCIL

Maternal Health.....	11/4 Detroit	4
	12/12 Lansing	
	5/18 Ann Arbor	
	6/7 Lansing	
Public Relations .....	1/22 Lansing	2
	3/23 Lansing	
Contact Com. of Gov't Agencies....	3/2 Lansing	6
	3/27 Flint	
	5/4 Lansing	
	5/21 Lansing	
	6/1 Lansing	
	6/22 Lansing	
Mental Hygiene .....	11/11 Detroit	3
	1/20 Detroit	
	3/24 Eloise	
Ethics .....	3/20 St. Louis	1
Occupational Diseases.....	10/21 Detroit	2
	1/11 Detroit	
Parole Commission, Advisory to....	12/12 Detroit	2
	1/17 Jackson	
Membership .....	No meeting; work done through correspondence	
Rep. to Mich. Health League.....	12/1 Detroit	3
	1/5 Pontiac	
	3/9 Pontiac	
Medico-Legal .....	4/2 Detroit	1
Liaison with Hospitals.....	3/16 Detroit	3
	4/13 Detroit	
	5/18 Eloise	
Liaison with State Bar.....	No meeting; contacts made direct with State Bar	
Committee on Scientific Work.....	2/20 Lansing	2
	3/27 Lansing	
Total Committee Meetings.....		60
Total Council and Executive Committee Meetings.....		11

## TOTAL MEETINGS PER MONTH

September	4	January	10	May	11
October	2	February	3	June	6
November	10	March	11	July	1
December	7	April	4	August	2

All committee work was reviewed by The Council and by the Executive Committee.

The Postgraduate Medical Education Committee has expanded its progressive program, and has opened a new center (in Ann Arbor). The detailed program in the Handbook for Delegates outlines the accomplishments of this committee. An innovation is the awarding of Certificates of "Associate Fellowship in P. G. Education," after four years' p. g. activity by physicians; and the Gold Award or full "Fellowship" after eight years' work. The future of medicine depends upon the quality of medical service given by the average practitioner of medicine. Postgraduate medical education is raising the quality of practice, and its augmentation will help solve some of the problems which face the profession.

The Legislative Committee made plans during the past year for the 1939 session of the Legislature and of Congress. Many legislative friends of 1937 are seeking re-election, which must be a signal for action on the part of the medical profession between now and election day, November 8. The Council recommends that no aggressive legislation be sought by the M.S.M.S. in 1939; however, many destructive proposals must be stopped, to the end that medical practice is kept on a high plane. The Legislative Committee sent a number of bulletins to the various key-men in the county medical societies during the past year.

Progressive work was done during the past

year by the Preventive Medicine Committee and its Syphilis Control Advisory Committee, which, among other activities, recommended desirable changes to improve the Antenuptial Physical Examination Law; by the Tuberculosis Control Advisory Committee, which coöperated with the Michigan Association of Roentgenologists to develop plans for the early diagnosis of tuberculosis; by the Committee of Radiologists; by the Ethics Committee; by the Iodized Salt Committee; by the very active Woman's Auxiliary Advisory Committee, representatives to the Joint Committee on Health Education; the Distribution of Medical Care Committee, which developed a comprehensive survey on medical care of indigents; the Cancer Committee; the Maternal Health Committee, which coöperated with the U. S. Public Health Service in a unique study; the Public Relations Committee on which the responsibility for the success of the A.M.A. Survey was thrown; the Contact Committee to Governmental Agencies (previously outlined); the Advisory Committee to Parole Commission (previously outlined); and the Liaison Committee with Hospital Association. A special committee of the Council, the Medico-Legal Survey Committee, made a study of medico-legal activities in other states of the nation, and presented concrete recommendations that medical defense be continued in this state but that certain changes be made to make it more efficient, which recommendations were adopted by The Council on August 3.

The Committee on Scientific Work developed the 1938 Annual Meeting, with a stellar program and many new attractions which should result in a splendid meeting and a record-breaking registration. It assigned a half-day and evening on the General Assembly to consideration of all phases of "Preventive Medicine."

The Council is grateful and thanks all committee-chairmen and members for their hard work performed in behalf of the 4,000 members of the M.S.M.S.

The cost of this increased committee activity, with benefits to every practitioner of medicine in the State, has been offset by a demonstration of greater activity, interest, and enthusiasm on the part of more M.S.M.S. members than has ever been apparent in our history. This esprit de corps cannot be measured in dollars and cents; but it must be maintained if the Society is to improve and to increase in size, importance and influence.

## Emergencies

With the increasing attempts of government to encroach upon the private practice of medicine, the M.S.M.S. has found itself faced with emergencies during the past year which required immediate action. The Socialized Medicine experiment of the HOLC agency in Washington, D. C., is a case in point; this can spread to include all Federal employees in all parts of the U. S., then take in state governmental employees, and finally those of cities, townships, counties, etc., etc., which means that these people will get mechanized service from a handful of politically-appointed physicians who will be inadequately compensated to take care of many of *your* private patients. The Scott Resolution introduced into the U. S. Congress this year, and the more recent statement of the U. S. Assistant Attorney General, both sought investigations of every medical society in the land. The emergencies of 1937-38 were met, as they arose. The implications of the Social Security Act, especially with reference to the U. S. Syphilis



Program, required our dispatching to Washington our President, Henry Cook, who alone of all who testified before the Congressional Committee gave the viewpoint of the general practitioner towards clinics for the care of syphilis in Michigan.

The Public Relations Committee was instructed to revise its brochure, "Who Wants Socialized or State Medicine!" because of many requests from other states, as well as from Michigan.

The requests of newspapers for statements on controversial questions were complied with, usually requiring emergency meetings and conferences.

Contacts were made with our two U. S. Senators and 17 Congressmen in Washington, on a number of important medical problems before Congress; friends in Congress were made, especially Congressman Paul W. Shafer of Battle Creek, who championed Medicine in Congress on 2 memorable occasions. A brief on the legal status of chiropractors was developed in the M.S.M.S. Executive Office at the request of a governmental agency.

In view of the multiplicity and increase of our general problems, the medical profession must sustain its activity and must look for an increase in civic endeavor and quasi-public work, as part of its more important and ever-increasing functions.

#### New Activities

The work of the "Placement Bureau" was increased during the past year, to such a point that hardly a week now goes by without at least half a dozen requests for aid in seeking good locations for medical practice in Michigan.

The "Spot Speakers Service" was created by action of The Council in June. This will aid county medical societies in despatching physicians to address lay groups—a very important activity.

In 1938 the Basic Science Board was appointed and organized.

During the past year, the right to institutional practice by osteopaths was decided by the Circuit Court of Genesee County; in this case, the M.S. became a party-defendant in order to aid local counsel with legal talent. A determination should be made in the very near future re the right of osteopaths to practice medicine and surgery generally, outside of public institutions.

The Society has a great interest in the Welfare Reorganization Referendum of November 8, and is sending to the membership the pros and cons giving both sides of the question.

The Council recommended to its A.M.A. delegates that they use their influence to secure a Public Relations Bureau in the A.M.A., which

plan however was not adopted by the A.M.A. House of Delegates at its San Francisco meeting.

#### Progress

The Michigan State Medical Society has made progress during the past year—startling progress, when we look back to the Sault Ste. Marie meeting of 1935 and review the recommendations of that House of Delegates, and compare it with the activities of the State Society today.

All the instructions of the House of Delegates have been followed out, to the best of the ability of your Council.

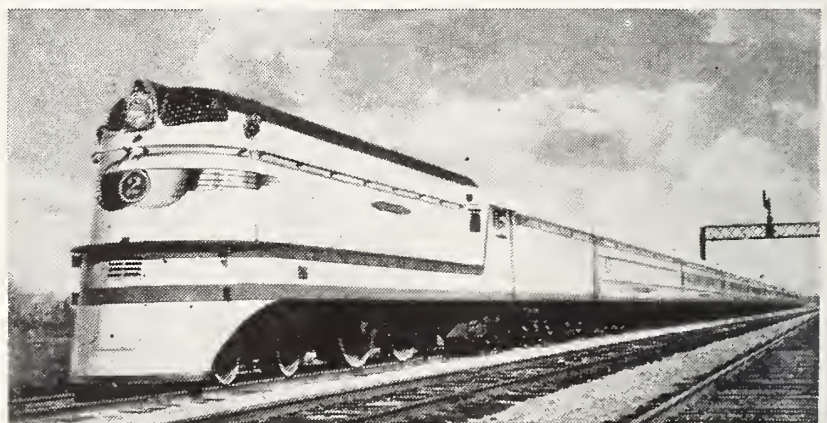
There is yet much to be done, especially with the problem of distribution of medical care, in particular to the relief group, a decision on "group hospitalization," the determination of findings as the result of the A.M.A. Survey, progressive plans if the Welfare Reorganization Laws of 1937 are approved on Election Day, and how to supply medical care to those in the borderline group who need it. In the future, we must expect greater problems and greater work, and therefore greater accomplishments. With continued unity and activity in our own ranks, augmented by even greater contact and coöperation from other unofficial and official groups and interested laymen, the M.S.M.S. and its 54 component county medical societies will go far in their attempt to solve—as they arise—all medical problems in this state. As stated in our report last year, our whole structure depends upon the allegiance of the practitioner of medicine to his county medical society, which exists only for the betterment and welfare of its physician-members and the people whom they serve.

Respectfully submitted,

P. R. URMSTON, M.D., *Chairman*  
HENRY R. CARSTENS, M.D.  
J. EARL MCINTYRE, M.D.  
WILFRED HAUGHEY, M.D.  
F. T. ANDREWS, M.D.  
VERNOR M. MOORE, M.D.  
I. W. GREENE, M.D.  
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W. A. MANTHEI, M.D.  
P. A. RILEY, M.D.

**A Streamlined Convention**  
is awaiting YOU  
in Detroit

September 19, 20, 21, 22



Courtesy C. M. St. P. & P. Ry.

# President's Page

## OUR WATCHWORD—UNITY

THE medical profession of Michigan is desirous that all people shall receive the medical care they need. This is equally true of the future as it has been in the past. Organized medicine has always made every effort to eliminate the quack and charlatan. It has eliminated medical colleges which did not give the student the highest professional training. It has carried on a campaign of health education of the laity. It has always been favorable to a more efficient program of preventive medicine.

It believes that the best in medical care can be attained for all the people under the American plan of distribution of medical care.

The medical profession believes that the practice of medicine should be kept under the control of the physician and that the politician is a very definite threat to good medical care in the future.

They believe that programs of improvement of medical care should be worked out by the medical profession jointly with various local, state and national public health agencies and it should be done without outside interference. The doctor believes that improvements in medical care and its distribution can be best accomplished by improvement upon past attainments rather than jeopardizing that which has already been accomplished.

The practice of medicine must remain sufficiently attractive and give proper financial return if it is to appeal to the best type of individual.

The doctor must keep cool and not be stampeded into surrendering the principles above outlined by accepting unworthwhile compromise.

Unity must be our watchword.



President, Michigan State Medical Society



# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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SEPTEMBER, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### THE ANNUAL MEETING

SEPTEMBER is the month of good things for the members of the Michigan State Medical Society. It is the opening month for the Society year and also of many of its constituent county medical societies. But we have in mind particularly the Society's annual convention. This has come to be such a large meeting that for the past two or three years it has alternated between Detroit and Grand Rapids, the two largest cities in the state.

The medical profession of Wayne County will be the hosts to the Society this year. The scientific and other programs appear in this number of THE JOURNAL. See for yourselves! The committees in charge of the scientific program have spared no

effort to make this one of the most outstanding that has been presented at any state convention, in the United States. Three days of postgraduate work in medicine will be offered.

The commercial exhibits are the most extensive, as well as novel and interesting, that have been shown at any state convention.

Provision is being made for entertainment as well as study.

Detroit welcomes you.

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### MEDICINE TO BE INVESTIGATED

APPROXIMATELY a month ago, two seemingly unrelated incidents took place. One was the threat of instituting legal proceedings against the medical society of the District of Columbia and the American Medical Association by Thurman Arnold, deputy Attorney-General of the United States, for alleged violation of the Sherman Anti-Trust Laws. Over a year ago, members of the H.O.L.C. in Washington formed an association with a substantial subsidy from the federal treasury. The purpose of the organization was to put into practice what has come to be dubbed State Medicine. The medical society of the District of Columbia in common with all other medical societies of the United States has some time or other expressed disapproval of the corporate practice of medicine, either orally or by denying membership to any doctor who sells his services to a corporation. We use the term "threat" as signifying the action of the assistant attorney-general inasmuch as his ultimatum published in full in the *Journal of the American Medical Association* of August 6th offers the American Medical Association and its component state and county societies an opportunity to change their attitude towards groups who may desire to organize along lines similar to those of the H.O.L.C. group.

In the event of the said medical associations standing pat, their actions will be subject to grand jury investigation to be followed by court proceedings should justification be found. So far as we see it, there is nothing in the attitude of medicine that members of the medical profession need to fear an impartial investigation. They will await the court decisions with intelligent interest.

The other incident referred to above was

the meeting of the National Health Conference which was held in Washington, D. C. An interesting editorial summary of this meeting appeared in the *Journal of the American Medical Association* of July 30th of this year. In attendance were physicians and representatives of correlated professions. Labor, mutual aid and welfare organizations, farm bureaus, hospital workers and government employees also had their representatives. Ten members represented the medical association.

The National Health Program made five recommendations based on its consideration of the health requirements of the United States. The first called for an expenditure of two hundred million dollars by federal, state and local governments for the purpose of public health organization. One half of this sum is to be provided by the federal government, the other half by state and county. In addition to this is one hundred and sixty-five million for the expansion of maternal and child health service. These services are for people of all income groups in all parts of the United States.

The second, third and fourth recommendations were for a ten-year program at an annual cost of \$146,500,000, half to be paid by the Federal Government and half by the municipalities. This is to provide new diagnostic and therapeutic services to the nation. The program also calls for an expenditure of \$400,000,000 yearly for the medically indigent, half of the sum to be provided by the federal government; the remainder by states and counties.

The fifth recommendation concerned loss of wages during sickness.

Should the recommendations of the National Health Conference be carried into effect, the cost in the increased tax levies will be truly astronomical. It is interesting to note here that there was a discussion on the subject of ways and means. A payroll tax was proposed in order to raise a portion of these huge sums. The C.I.O. representatives, it is reported, favored the gigantic expenditures but would not agree that a dollar of it should come out of industrial payrolls.

Apparently the idea in the minds of most reformers is that anything can be accomplished by the expenditure of enough money. We are reminded of the father who made inquiry of the principal of a ladies

college as to how his daughter Mary was getting along. The diplomatic professor replied, "Mary is a good girl and gives little trouble, but she doesn't have the capacity to learn." "Get her a capacity," replied the indulgent father, "and send in the bill and I'll pay it."

The medical profession are for the most part of one mind in their reaction to the recommendations of social reform. Every member of the medical profession should inform himself of the trend of mind of the intelligentsia. They are loud and will be heard and to a greater or less extent heeded by legislators, and hampering laws may result. The medical profession must make themselves heard, too. "It will be a sad day for society," declared Woodrow Wilson, "when the sentimentalists are encouraged to suggest all the measures that should be undertaken for the benefit of the human race."

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## SOCIALISTIC TRENDS

EVERY now and then we are told what the public wants. The public wants socialized or state medicine. To ascertain the reaction of that small portion of the public with whom we come in contact, we have put the question, Do you want state medicine? Are you in favor of socialized medicine? In almost every instance, we were confronted with a rejoinder. What do you mean by state medicine? Weary of explaining what state or socialized medicine is, we have desisted and have concluded the part of our public who so much desire socialized medicine are the social worker and the social reformer—the vociferous few and not the silent industrious majority.

It is still green in our memories that the Socialists ran a candidate for president—Norman Thomas—a candidate with personal qualities that should have secured for him a large following if his particular brand of political philosophy had any appeal to the nation. Socialism seems to flourish for the most part among the so-called intelligentsia—the parlor type.

Socialism, as all other political philosophies, pre-supposes two groups, a controlling or a regimenting group and the larger group—the controlled. There is no room for free discussion in the land of *isms*. Free discussion is interpreted as treason. The Amer-



ican people do not want anything of the sort. They are satisfied with democracy even with all its faults.

Should socialism become the form of government in the United States, we venture a prediction that neither Norman Thomas nor any of the academic variety of socialist would have anything to do with it. Who would have predicted Hitler even six years ago in "Germany, learned, indefatigable, deep-thinking Germany"; or Mussolini in Italy a dozen years ago? Government is too precious a thing for the unlearned and greedy politician to relinquish from his grasp simply for an ideal.

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"When a man like Doctor Cabot makes the ridiculous statement that thousands of young physicians are starving; then implies that the bulk of the lower economic third of the population is not receiving medical care, and then has these wild statements enthusiastically applauded and almost cheered, it is apparent that the meeting is not going to be judicial in its attitude. Such statements are reckless and unproved. If there are thousands of young doctors unable to make a living in this country, we would like to know where they are. Certainly they are not in this section." The *New Orleans Medical Journal* thus comments on Dr. Cabot's address at the National Health Conference in Washington.

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### STATE MEDICINE

(*New Orleans Medical and Surgical Journal*)

The splendid address of Dr. Charles M. Horton, delivered before the annual meeting of the Louisiana State Medical Society in May and published in the June issue of this journal, should be read carefully and digested thoroughly by every member of the State Medical Society. The address is replete with arguments showing why State Medicine would be harmful to the development of the medical profession in the United States and a distinctly detrimental method of practice as applied to the citizens of this state and country.

There are several statements in this address which well might be restressed and again accentuated. Horton writes, for example, that the practice of medicine is comparable to individual liberty. It is fundamentally an expression of the ethical life and it will suffer to a high degree if its liberty is invaded. State Medicine would contain evils which would probably be worse than those faults it purports to correct. Politics is likely to dominate State Medicine and health measures. Again, to paraphrase Dr. Horton, this is particularly dangerous because there are certain inherent faults with any large sys-

tem which is governed and controlled politically. He says, furthermore, that there is bound to be a rise in taxation, particularly of interest to those who are called upon to pay the taxes and who resent the present imposts.

Horton says State Medicine is the beginning of the end of state government. The Commonwealth gives up its privileges and prerogatives to let the central government dominate; where it dominates, eventually it controls; once a bureau is established it keeps on getting larger and larger and demanding more and more from the taxpayers.

The advancement of scientific medicine is dependent upon independence in medical practice. The independence of our citizenry has been gained through tremendous trial and prodigious expenditure of blood. Let us not lose the priceless heritage which our forefathers gained for us a century and a half ago; let us maintain our independence; let us preserve our intellectual and medical freedom.

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### SOCIALIZED MEDICINE

(*Editorial in the Chicago Daily News, Aug. 2*)

The announced intention of the Department of Justice to bring suit against the American Medical Association under the anti-trust laws raises some interesting questions.

The department, according to the New Deal's new trust buster, Assistant Attorney General Thurman Arnold, thinks that the anti-trust laws apply to the offering of services as well as to the production of goods. That, if we are not mistaken, is a new interpretation. The line between offering one's services and offering one's labor is hard to draw. If Mr. Arnold can make this new interpretation stick, will there not be a conflict between the Wagner act, which favors collective bargaining in the offering of labor, and the anti-trust laws, which might then be twisted into a weapon against trade unionism?

Specifically, the federal government charges that the American Medical Association is conspiring to make group health plans impossible, by expelling from the association doctors who join in such plans, and by forbidding its members to aid patients who subscribe to such plans. If it is true that the association does this, and does it in a spirit of opposition, not because it is seeking to maintain high ethical and technical standards in the profession, we think it is following a mistaken course. Mr. Arnold should produce the evidence.

But meanwhile, it is intimated that if the association will change its policy so as to encourage health plans in future, the government may drop its suit. Does this mean that the New Deal, in its continued mood of socialistic experiment, is bent now upon bringing about socialized medicine? If that is the real aim, the administration should say so plainly. Certainly the people are entitled to the best medical care that the science and devotion of the medical profession can provide. But is not the profession already giving such care? Every community has hospital arrangements for patients too poor to pay. Every conscientious physician and surgeon contributes some of his time without charge to the service of the poor, and does so quietly, as a matter of course. But we do not believe that the profession as a whole is in a mood to submit, even under pressure, to New Deal regimentation. And neither do we believe that the average American citizen is in a mood to let the government tell them, when he falls ill, which doctor he must have.

# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## COME TO THE STATE MEETING

**"YOUR** physician will be away September 19, 20, 21, 22 taking postgraduate work in Detroit" is the message people will see in your local newspaper during September. This and additional advance publicity will educate the public to the value they will receive, *through you*, from the annual meeting of the Michigan State Medical Society.

As a progressive member of the medical profession, a leader in your community, you must merit the people's confidence in you by making every effort to take advantage of the unusual opportunities of your State Society convention.

### A Rare Opportunity

The annual meeting of the Michigan State Medical Society offers:

1. An intensive and excellent postgraduate conference covering all branches of medicine, with
  - (a) Seven General Assemblies (27 out-of-state lecturers)
  - (b) Seven Section Meetings (25 speakers)
2. A full discussion of the socio-economic problems which face you in your practice (House of Delegates meeting).
3. Entertainment-golf-baseball-vacation features.
4. Symposium on "The Business Side of Medicine."
5. Good Fellowship—meeting old friends and making new ones.
6. An exhibit offering many new ideas and appliances to aid you in the successful practice of modern medicine.
7. A full program of entertainment for the ladies.

### Your Good Fortune

A seven-ring circus? Yes,—in scientific medicine. A big show, designed, planned and conducted for *You*, Doctor. A round of activities welded together to give the physicians of Michigan a finer appreciation of their good fortune in being members of the greatest service profession in the world.

You are invited and urged, Doctor, to be one of the two thousand practitioners of medicine who will register in Detroit, September 19, 20, 21, 22, 1938. Accept our invitation, fulfill the trust of the people in your community so you may continue to be one of its leaders.

SEPTEMBER, 1938

## SECRETARIES' CONFERENCE

**T**HE second Conference of County Secretaries for 1938 will be held Tuesday, September 20, at the time of the annual meeting in Detroit. Realizing that the county secretary is the key man of his local society, the conferences are designed to develop and sustain the inspiration which he must at all times demonstrate.

Every county secretary should attend the sessions of the annual meeting in order to become cognizant of the deliberations of the House of Delegates and to appreciate the developments in scientific medicine which will be presented in the general and section sessions.

The Secretaries' Conference as an integral part of the annual meeting will present a unique inspirational address by Dr. Williams Sadler of Chicago and will provide an opportunity for the interchange of ideas among the fifty-four secretaries, thereby aiding each society in the solution of its problems and of crystallizing the thought of the component units into a more consistent composite of the M.S.M.S.

Attendance at the Secretaries' Conference is both your opportunity and responsibility. Your County Society depends upon you, Dr. Secretary, as its pilot. Your efficiency cannot be developed and maintained unless you grasp each opportunity provided by the State Society—opportunities designed to aid your society both as a unit and its members as individuals.

Remember the date, Tuesday, September 20, at the Book-Cadillac Hotel, Detroit.

## COUNTY MEDICAL SOCIETIES

**T**HERE has never been a greater need for active, well-organized county medical societies. Officers and executive bodies of state medical societies should be able to devote their energies to the solution of current problems and be relieved of the responsibility of constantly urging county units to greater organizational efficiency.

Wherever problems of a socio-economic



or political complexion are difficult of solution, we usually find a poorly organized county medical society. Alert, aggressive societies are usually cognizant of what is transpiring in their territory and are able to develop constructive plans of solution and are asserting a real leadership in progressive movements and likewise are preventing the establishment of undesirable policies.

Only recently, a county medical society in Michigan found itself facing a situation which, if allowed to develop, would have seriously affected the practice of practically every doctor in the community. Energetic action, by the State society and members of the county society, tended to forestall the undesirable project. The movement might, by an active county medical society, have been stopped before it had assumed even such alarming proportions.

Let us develop each county society into an active component and be prepared, at all times, to defend the traditions of the American type of medical practice.

#### POLITICAL ECONOMY

Dae ye ken th' widow, Mistress Black,  
Wha lives doon i' th' slums,  
Th' slums that's doon there near th' track,  
Amid th' factory lums.\*

Weel, she's th' lass wha's man was kilt  
An' left her bairnies five,  
Noo that's enough tae mak one wilt  
An' leave nae strength tae strive.

Bit she took washings an' some work  
An' kept her brood of five,  
An' fed them beans an' cheaper cuts  
An' made them a' survive.

Noo, they've grown up an' through night school  
An' love their mither fine,  
They've helped tae keep her larder full,  
Her face wi'oot a line.

Oh, maun, cud politicians noo  
Learn frae this woman's skill,  
They'd earn their bread wi' butter on't,  
An' a' their promise fill.

Their studies in economy  
Are costing more'n they earn,  
An' going broke is irony  
From which they dinna learn.

Bit hae them a' gang doon th' tracks  
Tae switch light number three,  
Turn left three doors tae Widow Black's  
An' learn economy.

An' if they've no dumb heided men  
They'll hae their lesson learned,  
They'll ken tae live wi'in their plan  
An' plan tae spend no more'n they've earned.

WEELUM

\*lums—chimneys.

#### MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

#### PNEUMONIA SERUM TO BE DISTRIBUTED

The Michigan Department of Health, following three years of study in checking the effectiveness and improving the potency of pneumonia serum, is now prepared to distribute serum for Types I and II pneumonia to physicians throughout the state.

Nine serum distributing stations are already in operation at Detroit, Muskegon, Grand Haven, Grand Rapids, Lansing, Saginaw, Pontiac, Houghton and Marquette. Typing facilities are also available in thirteen other counties in lower Michigan. Distributing stations will be established in these counties as soon as local arrangements can be made.

To obtain state serum, physicians will be expected to have the type of pneumonia determined by a registered laboratory. A special form has been set up for the use of these typing stations, this form when properly filled out becoming both an order and a receipt for serum from the distributing stations if Type I or II serum is indicated.

At the time the serum is given out, the distributing station also provides the physician with the case report form. Physicians will be expected to complete and return these forms in the addressed envelope provided within thirty days of the onset of the illness.

There are approximately 74 pneumonia typing stations available at present. With the exception of the two stations at Houghton and Marquette, however, all of these are located below the Muskegon-Bay City line. Efforts are now being made by the Bureau of Laboratories, which is charged with the registration of laboratories in Michigan, to remedy this situation. A branch laboratory is being established at Powers in the Upper Peninsula to serve the southern and eastern communities in that area. Similar efforts are being made to develop typing facilities in the northern part of the Lower Peninsula. It is expected that adequate typing facilities will be available throughout the state before the advent of the pneumonia season this fall.

The Department is actively coöperating with the Subcommittee on Pneumonia of the Michigan State Medical Society's Preventive Medicine Committee. Through this committee, the pneumonia program will be given considerable attention in the Society's activities this fall with the provision of qualified speakers on pneumonia therapy. Arrangements are also being made to provide similar speakers on the postgraduate courses sponsored by the Society and the University of Michigan. The Joint Committee on Health Education has also agreed to co-operate in the lay health education program on pneumonia.

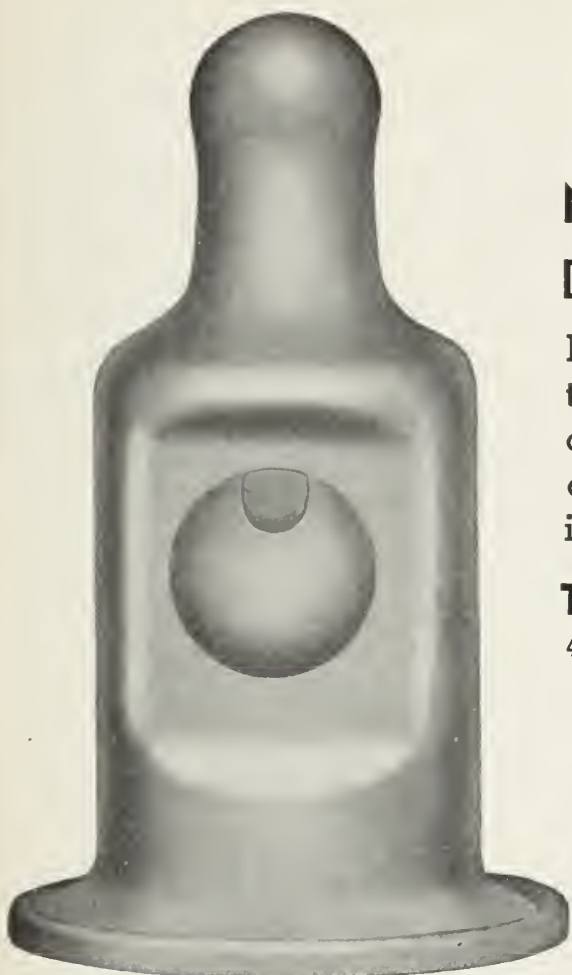
The county, district and municipal health officers will also take an active part in the development of the pneumonia program in their respective jurisdictions. In addition to arranging for the distribution of serum and the collection of reports, they will aid in the lay and professional education program.

\* \* \*

#### BUREAU OF PUBLIC HEALTH NURSING CREATED

A Bureau of Public Health Nursing will be organized September 1 as one of the administrative divisions of the Michigan Department of Health, it

(Continued on page 838)



Physicians pronounce this new nipple an unqualified success. The patented air valve regulates the flow of milk through control of the vacuum—nearest approach to nature. Used extensively by leading hospitals. On sale through drug and department stores.

# NursRite

## NEW SCIENTIFIC DEVELOPMENT

Developed by a group of pediatricians through extended tests in difficult feeding cases, the NursRite Nipple has proved correct in principle and embodies many important advantages. Samples on request.

### THE CILOCON CORPORATION

415 Francis Palms Bldg.

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The ONLY valve principle nipple that is 100% successful.





Since 1869

# A PURE HEALTHFUL MINERAL WATER

• Since its discovery in 1869 "Natural Ray" mineral water from the famous Magnetic spring at St. Louis, Michigan, has won authentic endorsement. Pure and healthful, it is one of the few American alkaline mineral waters considered worthy of mention in the Encyclopedia Britannica.

The modern physician will recognize in this unusually palatable and delicious water a normal way to eliminate waste. He will find the calcium, sodium and magnesium content correctly proportioned.

Natural Ray is very reasonably priced and is available from Distributors located in the principal cities throughout Michigan. It is bottled at the spring in 2 quart, sterile, green glass containers and in 5 gallon bottles.

Physicians are invited to write for descriptive literature and certified analyses.

**Michigan Magnetic  
Mineral Water Co.**  
St. Louis Michigan

has been announced by Dr. Don W. Gudakunst, commissioner.

The new bureau will be under the direction of Miss Helen Bean, who has been given a leave of absence from her present position as public health nursing consultant with the U. S. Public Health Service at Washington. All of the general nursing activities of the Department, including the supervision of county nursing programs, will be correlated under the new bureau. Nurses will be assigned by this bureau to assist in special projects conducted by other administrative divisions.

Heretofore, the Bureau of Maternal and Child Health has supervised the Department's public health nursing program. Child care class nurses and the field physicians and women's class organizers will be retained under the Bureau of Maternal and Child Health. The new bureau will be financed with the aid of maternal and child health funds granted to Michigan under the social security act.

\* \* \*

## RABIES COMMITTEE APPOINTED

An unusually extensive outbreak of rabies throughout the state which has already resulted in two deaths has brought joint action from the Michigan Department of Health, the Department of Agriculture and the Attorney General's Department. Prime objective of the attack will be control of the stray dog through stricter control of quarantine.

It has been estimated that 5,000 children have been bitten by dogs this year. The prevalence of the disease is indicated in that more than 45 per cent of the dogs examined at the Department of Health laboratories recently have been infected with rabies. Rabies vaccine for the treatment of 5,500 persons has been prepared and distributed by the Department laboratories this year at a cost of approximately \$15,000.

A joint Committee on the Control of Rabies in Michigan has been appointed to seek ways and means of curbing the present outbreak of rabies and preventing future outbreaks. Members of this committee include Assistant Attorney General John F. Young; Dr. Filip C. Forsbeck, director of the Bureau of Epidemiology of the Michigan Department of Health; Dr. Herbert W. Emerson, director of the Pasteur Institute, Ann Arbor; Dr. C. H. Clark, State veterinarian; and Dr. Joseph A. Kasper, director of the Detroit Health Department laboratories.

At its meeting July 22, the committee adopted a unanimous resolution to the effect that responsibility for the enforcement of dog quarantines rests upon the law-enforcement agencies of the local community and called upon these agencies to make such quarantines effective. Dog quarantines, according to law, may be issued by the State Veterinarian upon the request of local officials, but once the quarantine is laid its enforcement is entirely in the hands of the local community. The committee agreed that there is no way provided for the Department of Agriculture to issue permits for transportation of dogs outside of quarantined areas. Local officials issuing such permits do so on their own responsibility.

Although cases of rabies in humans are now reportable to the Michigan Department of Health, there is no way to determine just how many persons have been bitten. The committee recommended to the State Health Commissioner and the State Council of Health that all cases of human beings who have been bitten by dogs be made immediately reportable to the Michigan Department of Health.

The committee is now studying the need for revision of existing quarantine laws and is drawing up recommendations regarding methods for the treatment of rabies in humans. An active public

(Continued on page 840)



SMITH, KLINE & FRENCH LABORATORIES

announce that

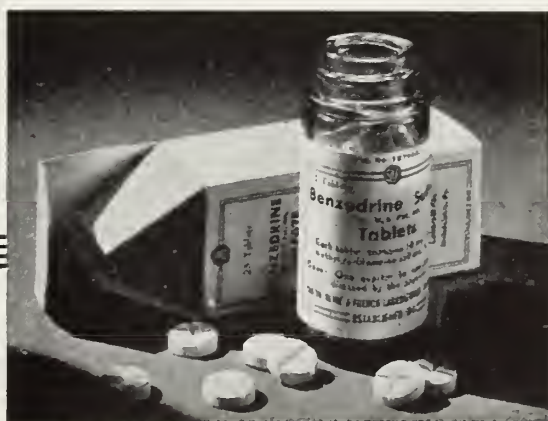
# BENZEDRINE SULFATE TABLETS

have been accepted

by

The Council on Pharmacy and Chemistry  
of the American Medical Association

*The announcement of acceptance appeared  
in the July 2nd issue of the J. A. M. A.*



Each 'Benzedrine Sulfate Tablet' contains amphetamine sulfate, 10 mg. (approximately 1/6 gr.)

The Council on Pharmacy and Chemistry of the A. M. A. has adopted amphetamine as the descriptive name for  $\alpha$ -methylphenethylamine, the substance formerly known as benzyl methyl carbinamine. 'Benzedrine' is S. K. F.'s trademark for their brand of amphetamine.

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.  
*Established 1841*





## CO-ORDINATION

When the success of a plan depends upon its perfect execution there must be strict co-ordination between the individuals involved.

No program of treatment can relieve the incidence of constipation unless the patient is willing to co-ordinate his efforts with those of the physician. That is why so many doctors prescribe Petrolagar for their patients. Its pleasant taste and gentle, consistent action are acceptable to the patient as well as to the physician.

Five types of Petrolagar provide a choice of medication to suit the individual case. Samples on request.

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*Petrolagar . . . Liquid petrolatum  
65 cc. emulsified with 0.4 Gm. agar  
in a menstruum to make 100 cc.*



education program is being sponsored to acquaint laymen with preventive measures for the protection of dogs as well as human beings.

\* \* \*

### COMMUNICABLE DISEASE MORBIDITY AND MORTALITY

Most prevalent communicable disease during the first five months of 1938 has been measles as was predicted early in the year. A total of 67,137 cases has already been reported, closely approaching the last epidemic year in 1935 when 79,061 cases were reported for the entire year. The peak was reached in March this year when 22,135 cases occurred. April cases declined to 17,574 and May to 13,892.

Scarlet fever was the second most prevalent communicable disease during this period, a total of 11,016 cases being reported. Whooping cough cases totaled 5,165. There were 170 cases of smallpox, 241 cases of diphtheria, 108 cases of typhoid fever, 63 cases of undulant fever, 34 cases of meningitis and nine cases of poliomyelitis during the five months ending May 31.

Mortality from measles during the first four months of the year accounted for 63 deaths. There were 49 deaths from scarlet fever. Whooping cough caused 26 deaths; diphtheria, 17 deaths; erysipelas, 14 deaths; typhoid fever, 11 deaths; and poliomyelitis, one death.

\* \* \*

### VITAL STATISTICS FOR 1937

Official vital statistics for Michigan in 1937 released recently by the Bureau of Records and Statistics indicate a state mortality rate of 10.50 deaths per 1,000 population. The rate in 1936 was 10.78. A total of 53,468 deaths were reported in 1937 compared with 54,777 the previous year. All rates are determined upon a population estimate of 5,093,000 in 1937.

For the fourth consecutive year a slight increase is recorded in the birth rate. There were 91,566 births in 1937 with a birth rate of 17.98 per 1,000 population, the highest since 1931. This was an increase of 3,109 births over the 1936 total.

The infant mortality rate in 1937 was the lowest ever recorded in Michigan with the exception of 1935. There were 4,374 deaths of infants under one year of age with a rate of 47.77 deaths per 1,000 live births. The 1936 rate was 50.63 when 4,479 infant deaths were reported.

A new low maternal mortality rate was established in 1937. There were 326 deaths of mothers from causes connected with pregnancy and childbirth, a maternal mortality rate of 3.56 per 1,000 live births. This is a 25 per cent decrease from the 1936 rate of 4.80 when 425 maternal deaths were reported.

The greatest number of marriages since 1924 was reported last year in Michigan. There were 47,954 marriages compared to 47,023 in 1936 and 28,552 in the low year of 1932. Divorces, too, increased to 12,472, the largest number ever reported in a single year. The highest number of divorces previously reported was in 1929 when 12,094 were granted. There is an average of one divorce to four marriages in Michigan.

\* \* \*

### PRINCIPAL CAUSES OF DEATH IN 1937

Ten principal causes of death accounted for 70 per cent of the total mortality in Michigan in 1937. Of the total of 53,468 deaths, 37,477 were the combined toll of heart disease, cancer, apoplexy, pneumonia, coronary disease and angina, nephritis, accidents exclusive of automobile, automobile accidents, tuberculosis and diabetes.

Heart disease caused 9,726 deaths last year, a mortality rate of 190.97 per 100,000 population. This



# A Desirable Location — —

PROFESSIONAL men agree that the Stroh Building is a desirable location. It offers modern, comfortable facilities for their patients in a building where high standards, convenience and prestige have kept pace with medicine and science.



New air-conditioned, quota-controlled, elevators have recently been installed. They represent the ultimate of perfection in present day vertical transportation systems.

*Reasonable Rentals*

## STROH BUILDING

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Detroit, Michigan

was the largest decrease in mortality from this cause in recent years. The 1936 rate was 197.04 when 10,010 deaths occurred.

Cancer, too, was marked by the first decrease in mortality for some time. Cancer accounted for 5,528 deaths compared with 5,543 in 1936. The mortality rates are 108.54 for 1937 and 109.11 for 1936.

Apoplexy replaced pneumonia as the third major cause of death in 1937. There were 4,195 deaths from apoplexy with a mortality rate of 82.37. In 1936, there were 4,529 deaths and a rate of 89.15.

Pneumonia mortality was practically stationary with 4,098 deaths last year compared to 4,096 deaths in 1936. The 1937 mortality rate for this disease was 80.46 per 100,000 population.

Coronary disease and angina as the fifth major cause of death accounted for a mortality of 3,045. The rate was 59.79 deaths per 100,000 population.

Nephritis mortality in 1937 was the lowest in the past ten years. There were 2,931 deaths due to this cause compared to 3,033 in 1936. The comparative mortality rates were 57.55 in 1937 and 59.70 in 1936.

Accidental deaths, excluding those caused by automobiles, were in seventh place with a toll of 2,405 lives. The rate for such deaths was 47.22 per 100,000 population. Automobile deaths alone occupied eighth place. There were 2,175 automobile deaths making the all-time high record for this cause. The rate for 1937 was 42.71.

Tuberculosis, the ninth major cause of death, again failed to decline in 1937, continuing the slight increase first indicated in 1936. There were 2,119 deaths from this cause in 1937 with a rate of 41.61 compared to 2,100 deaths and a rate of 41.34 in 1936. The lowest tuberculosis death rate of 40.24 was established in 1935.

Diabetes in tenth place accounted for 1,255 deaths, a rate of 24.64 deaths per 100,000. This is a slight decline from the 2,266 deaths and the rate of 24.92 in 1936 but it is considerably higher than the mortality experienced previous to 1934.

\* \* \*

### OBSTETRICAL CONSULTANT SERVICE

A field consultant service in obstetrics has been inaugurated by the Bureau of Maternal and Child Health for the physicians of Michigan. Dr. Clair Folsome, who has been senior instructor in the Department of Obstetrics and Gynecology at the University of Michigan for the past five years, has been appointed to take charge of this program.

Dr. Folsome will carry on his activities in conjunction with the maternal health committees of the county and district medical societies. His services are freely available to all physicians, but at no time will he replace physicians who usually assist at deliveries.

The obstetrical consultant service may be obtained by any local medical society upon request. Dr. Folsome's schedule allows him to spend a week in each area. During July and August his services were available in Manistee, Wexford, Grand Traverse, Mecosta, Genesee and Crawford counties.

\* \* \*

### POSTGRADUATE OBSTETRICAL TRAINING

Dr. Sprague H. Gardiner, senior instructor in the Department of Obstetrics and Gynecology, University of Michigan, has been assigned to the staff of the Michigan Department of Health to direct the short course of postgraduate instruction in obstetrics and gynecology being sponsored by the Bureau of Maternal and Child Health. Dr. Gardiner will serve under the direction of Dr. Norman F. Miller, head of the Department of Obstetrics and Gynecology.



The postgraduate course provides for two weeks of intensive training and observation in obstetrics, gynecology and allied subjects at University Hospital. Two practicing physicians are appointed for each period.

Appointees for the quarter beginning Oct. 1 include Dr. William Winter, Holland; Dr. Marvin Meengs, Muskegon Heights; Dr. N. H. Clark, Holland; Dr. H. C. Irvin, Holland; Dr. W. R. Lyman, Dowagiac; Dr. George Loupee, Dowagiac; Dr. Clayton H. Palmer, Cassopolis; Dr. Saba Kessler, Bay City; Dr. G. D. Bos, Holland; and Dr. O. D. Stryker, Fremont.

\* \* \*

#### POSTGRADUATE EDUCATION IN CHILDREN'S DENTISTRY

The Michigan Department of Health in coöperation with the Postgraduate Division of the University of Michigan School of Dentistry and the Michigan State Dental Society is offering a series of postgraduate seminars in children's dentistry at seven Michigan cities starting the week of September 13.

The course will be given on three days at each center with Dr. Kenneth A. Easlick, professor of children's dentistry at Ann Arbor, Dr. Walter C. McBride of Detroit and Dr. C. W. Wilson of Detroit as special lecturers and clinicians. Centers where the course will be presented include Port Huron, Saginaw, Alpena, Lansing, Grand Rapids, Kalamazoo and Jackson.

\* \* \*

#### FELLOWSHIPS IN HEALTH EDUCATION

Six fellowships for training in public health education will be offered instructors in Michigan colleges as a part of the Michigan Department of Health's program for improving the health education of teachers. The fellowships will enable in-

structors at Wayne University, Michigan State College and the teachers' colleges to receive a year's training in public health. The instructors will then return to their institutions to conduct health education courses for students who are preparing to become school teachers.

\* \* \*

#### CASS COUNTY MATERNITY NURSING SERVICE

The staff of the Cass County Maternity Nursing Service have attended 62 home deliveries during the six months that this demonstration project has been conducted by the Michigan Department of Health. There have been 182 prenatal cases admitted to nursing service and 152 postnatal cases during this period.

Miss Harriet Hird is the supervising nurse in charge of the Cass County project assisted by Miss Fern Welsh and Miss Kathryn McCormick. In addition to the home deliveries attended with local physicians, the nurses have made 230 postpartum bedside calls. The staff has also conducted an infant and preschool hygiene program for a total of 302 cases during the six months ending June 30.

In the future in this county the stork may arrive to the accompaniment of a representative of the law. The county sheriff's department has agreed to send a deputy to accompany the nurses on all night delivery calls.

\* \* \*

#### WOMEN'S HEALTH CLASSES POPULAR

An increasing interest in popular health instruction is indicated in one of the largest enrollments ever attained in the women's health classes conducted by the Bureau of Maternal and Child Health during the past year. A total of 8,256 mothers and prospective mothers in 13 Michigan counties enrolled

(Continued on page 844)

*When in need of* **UNUSUAL**

• **AMPOULES**

• **BIOLOGICALS**

• **LABORATORY SUPPLIES**

*Call:*

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**PRESCRIPTIONIST**

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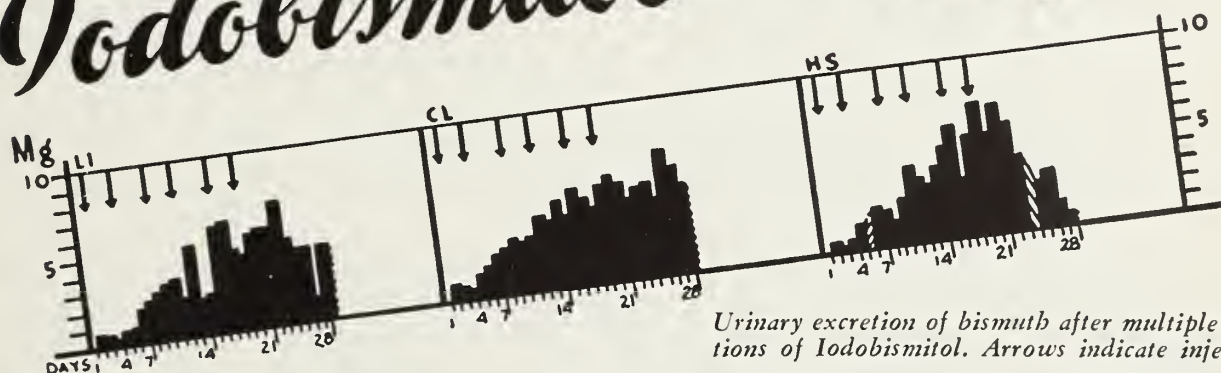
**DETROIT - TYler 4-3500**

***Prompt, Motorized Delivery Service***



**FOR  
SUSTAINED  
BISMUTH  
EFFECT  
USE**

*Iodobismitol with Saligenin*



*Urinary excretion of bismuth after multiple injections of Iodobismitol. Arrows indicate injections*

ACCORDING to the Council on Pharmacy and Chemistry—"Probably those compounds of bismuth will have the best spirocheticidal effect that are able to keep the therapeutic level of bismuth at such a continuous height that it will be reflected in the urine with a level of 0.002 Gm. or more of metallic bismuth per day."

That Iodobismitol with Saligenin meets this requirement was shown by a recent clinical study.<sup>1</sup> Two-cc. doses of Iodobismitol with Saligenin were given twice weekly for three weeks. The charts illustrated above show the urinary excretion over a period

of four weeks—49% of the bismuth having been excreted. Iodobismitol with Saligenin was the only preparation so studied capable of maintaining a therapeutically active concentration of bismuth in the blood stream as manifested by a constant urinary excretion equivalent to or in excess of 0.002 Gm. daily.

Iodobismitol with Saligenin may be used alone or with the arsenicals in both early and late syphilis. It presents bismuth largely in anionic (electro-negative) form. It is a propylene glycol solution containing 6% sodium iodobismuthite, 12% sodium iodide, and 4% saligenin (a local anesthetic).

### SQUIBB ARSENICALS

Nearsphenamine Squibb, Arsphenamine Squibb, and Sulpharsphenamine Squibb are prepared to produce maximum therapeutic benefit. They are subjected to exacting controls to assure a high margin of safety, uniform strength, ready solubility, and high spirocheticidal activity.

*For literature write to Professional Service Dept., 745 Fifth Ave., New York*

<sup>1</sup> Sollmann, T., Cole, H. N., Henderson, K., et al.: *Amer. J. Syph., Gon. & Ven. Dis.* 21:480 (Sept.), 1937.

**E·R·SQUIBB & SONS, NEW YORK**  
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858.



for the series of classes conducted by Dr. Berneta Block and Dr. Emily Ripka. An average of 60 women enrolled in each of the 136 classes.

Counties where lectures were given this year include Wexford, Grand Traverse, Charlevoix, Otsego, Leelanau, Cass, Lapeer, St. Joseph, Oakland, Huron, Manistee, Alcona and Alpena. Local medical societies gave their approval and coöperation in the organization of the classes.

The six lectures given each class included illustrated discussions of first aid, our body and how it functions, the beginning of life and the care of the woman during pregnancy and following delivery, the care and training of young children, preventing communicable diseases, and the challenge of cancer.

Starting in September, the classes will again be sponsored in various counties throughout the state.

\* \* \*

### PERSONNEL

Dr. W. J. V. Deacon, director of the Bureau of Records and Statistics, Michigan Department of Health, has been appointed by Secretary of State Cordell Hull as one of the nine delegates from the United States to attend the meeting of the International Commission for the Decennial Revision of the International Nomenclature of Diseases to be held at Paris, France, beginning October 3, 1938.

Dr. Philip E. Bourland has recently joined the staff of the Bureau of Epidemiology where he will assist Dr. Filip Forsbeck, director, as field epidemiologist. Dr. Bourland is a graduate of the University of Michigan School of Medicine, serving at

University Hospital and Blodgett Memorial Hospital, Grand Rapids. His home is at Calumet, Michigan.

Dr. George C. Stucky, former director of the Ingham County Tuberculosis Hospital, becomes director of the Eaton County Health Department on September 1. Dr. Stucky graduated from the University of Michigan School of Medicine in 1923 and served for a time with the Michigan Department of Health before entering tuberculosis work in Ingham County.

*The Hand-Shakers*—In the course of a duel in France, the parties discharged their pistols without effect, whereupon one of the seconds proposed that the combatants should shake hands. To this the other second objected.

"It is quite unnecessary," said he. "Their hands have been shaking for half an hour."

—Arrow.

\* \* \*

*Impedimented Speech*—It is said that people who stammer often sing well. A deck hand who suffered from an impediment in his speech ran to the captain on the bridge during a storm and started "P-p-please, s-s-sir."

"For goodness sake hurry up," said the captain irritably. "If you can't say it, sing it."

The deck hand took a very long breath and sang—"Should auld acquaintance be forgot and never brought to mind, the first mate's fallen overboard, he's half a mile behind."—Montreal Star.

## INTERNATIONAL MEDICAL ASSEMBLY



Inter-State Postgraduate Medical Association of North America  
Public Auditorium, Philadelphia, Pa. OCTOBER 31, NOVEMBER 1, 2, 3, 4, 1938

Pre-assembly clinics, October 29; Post-assembly clinics, November 5, Philadelphia hospitals  
President, Dr. Elliott P. Joslin; President-Elect, Dr. George W. Crile  
Chairman, Program Committee, Dr. George W. Crile; Managing-Director, Dr. William B. Peck  
Secretary, Dr. Tom B. Throckmorton; Director of Exhibits, Dr. Arthur G. Sullivan  
Treasurer and Director Foundation Fund, Dr. Henry G. Langworthy  
Chairman, Philadelphia Committees, Dr. Louis H. Clerf

ALL MEDICAL MEN AND WOMEN IN GOOD STANDING CORDIALLY INVITED

Intensive Clinical and Didactic program by world authorities  
The following is a major list of members of the profession who will take part on the program:

Alfred W. Adson, Rochester, Minn.	William D. Haggard, Nashville, Tenn.	George E. Pfahler, Philadelphia, Pa.
Walter C. Alvarez, Rochester, Minn.	George A. Harrop, New York, N. Y.	Fred W. Rankin, Lexington, Ky.
Wayne Babcock, Philadelphia, Pa.	Charles G. Heyd, New York, N. Y.	Robert F. Ridpath, Philadelphia, Pa.
Claude S. Beck, Cleveland, Ohio	Fred J. Hodges, Ann Arbor, Mich.	David Riesman, Philadelphia, Pa.
George Blumer, New Haven, Conn.	Chevalier Jackson, Philadelphia, Pa.	Leonard G. Rowntree, Philadelphia, Pa.
Peter T. Bohan, Kansas City, Mo.	Chevalier L. Jackson, Philadelphia, Pa.	Thomas H. Russell, New York, N. Y.
William F. Braasch, Rochester, Minn.	Elliott P. Joslin, Boston, Mass.	E. Kost Shelton, Los Angeles, Cal.
Richard B. Cattell, Boston, Mass.	Frederick J. Kalteyer, Philadelphia, Pa.	Fred M. Smith, Iowa City, Iowa
Henry A. Christian, Boston, Mass.	Floyd E. Keene, Philadelphia, Pa.	Marius N. Smith-Petersen, Boston, Mass.
Arthur C. Christie, Washington, D. C.	Herman L. Kretschmer, Chicago, Ill.	Alfred Stengel, Philadelphia, Pa.
Edward D. Churchill, Boston, Mass.	Frank Lahey, Boston, Mass.	Charles Stockard, New York, N. Y.
Dr. Louis H. Clerf, Philadelphia, Pa.	Dean Lewis, Baltimore, Md.	Cyrus C. Sturgis, Ann Arbor, Mich.
W. McK. Craig, Rochester, Minn.	Walter I. Lillie, Philadelphia, Pa.	Robert G. Torrey, Philadelphia, Pa.
George W. Crile, Cleveland, Ohio	Perrin H. Long, Baltimore, Md.	William G. Turner, Montreal, Canada
John S. Coulter, Chicago, Ill.	Warfield T. Longcope, Baltimore, Md.	Professor von Eicken, Berlin, Germany
Elliott C. Cutler, Boston, Mass.	William E. Lower, Cleveland, Ohio.	Waltman Walters, Rochester, Minn.
Walter E. Dandy, Baltimore, Md.	Charles W. Mayo, Rochester, Minn.	G. Harlan Wells, Philadelphia, Pa.
William Darrach, New York, N. Y.	Irvine McQuarrie, Minneapolis, Minn.	Allen O. Whipple, New York, N. Y.
Vernon C. David, Chicago, Ill.	James H. Means, Boston, Mass.	Paul D. White, Boston, Mass.
Loyal Davis, Chicago, Ill.	Arthur R. Metz, Chicago, Ill.	Hugh H. Young, Baltimore, Md.
Robert S. Dinsmore, Cleveland, Ohio	William S. Middleton, Madison, Wis.	
Claude F. Dixon, Rochester, Minn.	John J. Moorhead, New York, N. Y.	<b>TENTATIVE FOREIGN ACCEPTANCES:</b>
Nicholson J. Eastman, Baltimore, Md.	George P. Muller, Philadelphia, Pa.	Rt. Hon. Lord Horder, London, England
Edmond M. Eberts, Montreal, Canada	Clay Ray Murray, New York, N. Y.	Mr. A. Lawrence Abel, F.R.C.S., London, England
E. L. Eliason, Philadelphia, Pa.	John H. Musser, New Orleans, La.	Sir John Fraser, Edinburgh, Scotland
Charles A. Elliott, Chicago, Ill.	Howard C. Naffziger, San Francisco, Cal.	Professor Mario Donati, Milan, Italy
John F. Erdmann, New York, N. Y.	Frank R. Ober, Boston, Mass.	Professor Roberto Alessandri, Rome, Italy
Clarence B. Farrar, Toronto, Canada	Eric Oldberg, Chicago, Ill.	Professor Ferdinand Sauerbruch, Berlin, Germany
John R. Fraser, Montreal, Canada	Oliver S. Ormsby, Chicago, Ill.	
John C. Gittings, Philadelphia, Pa.	Hubley R. Owen, Philadelphia, Pa.	
Russell L. Haden, Cleveland, Ohio	Wilder Penfield, Montreal, Canada	

HOTEL HEADQUARTERS  
Benjamin Franklin Hotel

### HOTEL RESERVATIONS

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Final program mailed to all members of the medical profession in good standing, September 1.

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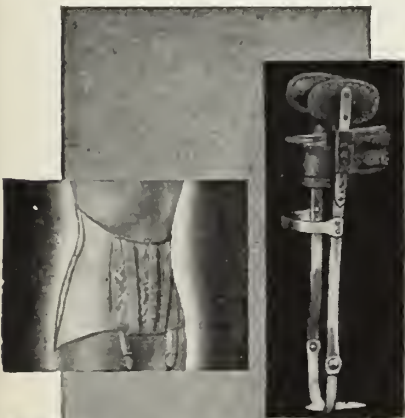
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## COMMUNICATIONS

### PRACTICE BY CORPORATIONS

Through the kindness of Dr. J. E. McIntyre of Lansing, Secretary of the Michigan State Board of Registration in Medicine, we are privileged to publish the following opinion from the office of the Attorney General of the state. This is particularly important as well as interesting at this time, when corporate practice of medicine appears to be in the offing.

State of Michigan  
Office of the  
ATTORNEY GENERAL  
Lansing, Michigan  
August 3, 1938

State Board of Registration in Medicine  
100 West Allegan Street  
Lansing, Michigan

Attention: Dr. J. E. McIntyre, Secretary.  
Gentlemen:

We have your communication of July 15, requesting our opinion on the following matters:

"1. Is it illegal for a corporation to practice Medicine under Act 237, Public Acts of 1899, as amended?"

"2. What is your interpretation of the last three lines of Section 3 of Act 237, Public Acts of 1899, as amended, which state: 'Provided that this section shall not apply to such forms of contract practice as are from time to time endorsed by this Board'?"

In answer to your first inquiry, it is our opinion that under the Michigan Medical Practice Act, being Act No. 237, Public Acts of 1899, as amended, it is not possible for a corporation to qualify so as to be entitled to practice medicine.

The question as to the right of a corporation to practice medicine has been considered by many courts, and the weight of authority is in accordance with the decision of the Supreme Court of the State of Illinois in the case of People of the State of Illinois v. United Medical Service, Inc., which is reported in 362 Ill. 442, 200 N. E. 157.

In that case the Illinois Supreme Court determined that a medical practice act forbidding the practice of medicine by unlicensed persons, making the passing of an examination a condition of the issuance of the license, and requiring that the applicant shall have attained the age of 21 years and be of good moral character and have certain educational qualifications, manifests a legislative intent that licenses shall be issued to individuals only, and not to corporations.

The Medical Practice Act of Michigan is similar in these respects to that of Illinois.

It is our opinion that under the Michigan Medical Practice Act a corporation cannot practice medicine. See also annotation in 103 American Law Reports, page 1240.

You further ask for our interpretation of the last three lines of Section 3 of Act No. 237, Public Acts of 1899, as amended, which state: "Provided that this section shall not apply to such forms of contract practice as are from time to time endorsed by this board."

No definition of what constitutes contract practice is contained in the act: but in the medical profession it is commonly understood to mean that practice by which physicians undertake to treat a group of persons as, for instance, the employees of an industrial concern, in return for a fixed compensation received from the owner or operator of the concern.

It is our opinion that this provision was meant to be considered in connection with the various subdivisions of Subsection 6 of said Section 3, which state the various grounds on which the Board may refuse to issue or revoke a certificate of medical registration, and was particularly intended to be construed in connection with subdivision (h) of said subsection, which provides in part that the State Board of Registration in Medicine may refuse to issue or continue a certificate if a person employs or is employed by any capper, solicitor or drummer for the purpose of securing patients.

We trust that the foregoing answer the questions contained in your letter.

Very truly yours,  
RAYMOND W. STARR,  
Attorney General.  
By SAMUEL B. OSTROW,  
Attorney General Chief Assistant.

AGL:av

### MATERNAL HEALTH OF MICHIGAN

THE JOURNAL has received the following communication from Dr. Alexander M. Campbell, Chairman of the Committee on Maternal Health of the Michigan State Medical Society. We give below a list of officers of the various Maternal Health Committees of the county medical societies of the state. The state committee suggests the following activities for the county medical society committees:

1. Assume practical interest in all matters pertaining to Maternal Health in your own county and see that prospective mothers receive the necessary maternal care in an adequate and intelligent manner.
2. Stimulate your fellow members to a greater interest in obstetrical work.
3. Develop within your own Society speakers to discuss obstetrical subjects and arrange through the Program Committee to import outside speakers to address the Society on obstetrical problems at least twice a year.
4. Arrange to have women's clubs and other groups of women addressed on obstetrics by either local or other physicians.
5. Investigate the mortality and morbidity associated with obstetrical work in your own county.
6. Endeavor to educate all expectant mothers in the county to place themselves under obstetrical supervision just as soon as the condition of pregnancy is suspected.
7. Encourage all parous women to submit themselves to proper postnatal care and periodical pelvic examinations following the birth of each child.
8. Investigate the type of obstetrical service rendered by physicians in your county who are not members of the Medical Society.

ALEXANDER M. CAMPBELL, M.D.  
Chairman, Committee on Maternal  
Health, Michigan State Medical  
Society

### THE COMMITTEES ON MATERNAL HEALTH OF THE COUNTY MEDICAL SOCIETIES IN MICHIGAN

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Dr. E. W. McKelvey, Oscoda  
Dr. J. M. Trudeau, Rogers City

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Battle Creek  
Dr. Philip B. Bonifer, Central National Tower, Battle  
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Dr. Wendell Stadle, Security Bank Tower, Battle Creek

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Dr. George E. Loupee, Dowagiac

#### Chippewa County

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Dr. W. G. Birch, Sault Ste. Marie  
Dr. D. F. Scott, Sault Ste. Marie

## COMMUNICATIONS

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 Dr. F. D. Richards, DeWitt  
 Dr. C. T. Foo, St. Johns
- Delta County**  
 Dr. Louis Groos, Chairman, Escanaba  
 Dr. G. W. Moll, Escanaba  
 Dr. James Mitchell, Gladstone
- Dickinson-Iron Counties**  
 Dr. R. D. Smith, Chairman, Iron Mountain  
 Dr. Harry Haight, Crystal Falls  
 Dr. E. B. Anderson, Iron Mountain
- Eaton County**  
 Dr. Bert Van Ark, Chairman, Eaton Rapids  
 Dr. L. G. Sevensen, Charlotte
- Genesee County**  
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 Dr. Max Burneli, Flint  
 Dr. E. C. Mosier, Otisville  
 Dr. V. H. Morrissey, Flint  
 Dr. I. H. Gutow, Flint  
 Dr. C. K. Stroup, Flint  
 Dr. F. B. Miner, Flint
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 Dr. M. J. Liberthal, Ironwood
- Grand Traverse-Leelanau-Benzie Counties**  
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 Dr. C. I. Ellis, Suttons Bay
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 Dr. G. F. Brewington, Mohawk
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 Dr. F. O. Kirker, Sandusky  
 Dr. E. W. Blanchard, Deckerville
- Huron County**  
 Dr. Chas. Herrington, Chairman, Bad Axe
- Dr. W. B. Holdship, Woly  
 Dr. J. B. Henderson, Pigeon
- Ingham County**  
 Dr. Frank Troost, Chairman, Holt  
 Dr. Harold Miller, Lansing  
 Dr. E. J. Robson, Lansing
- Ionia-Montcalm County**  
 Dr. I. S. Lilly, Chairman, Stanton  
 Dr. Roy C. Lintner, Ionia  
 Dr. M. A. Hoffs, Lake Odessa
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 Dr. Corwin S. Clarke, 605 Dwight Block, Jackson  
 Dr. Ferdinand Cox, 604 Peoples National National Bank Bldg., Jackson
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 Dr. Sherman Gregg, Kalamazoo  
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 Dr. Duncan A. Cameron, Brighton
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 Dr. A. M. Rothman, East Detroit  
 Dr. J. N. Scher, Mt. Clemens
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## ◆ General News and Announcements ◆

A conference on rural medicine will be held at the Mary Imogene Bassett Hospital, Cooperstown, N. Y., on October 7-8, 1938.

\* \* \*

The A.M.A. has prepared a booklet on "Group Hospitalization Insurance," which is available upon request. Write 535 No. Dearborn Street, Chicago.

\* \* \*

Wm. M. German, M.D., Pathologist and Director of Laboratories at Blodgett Hospital, Grand Rapids, since 1932, has accepted a position as pathologist in the Good Samaritan Hospital in Cincinnati.

\* \* \*

F. C. Warnshuis, M.D., announces his removal to Boston, where he is permanently located at 137 Newberry Street, as President and Editor-in-chief of the American Medico-Legal Association.

\* \* \*

The Basic Science Board met in the Governor's office in Lansing on Tuesday, August 2, and organized. Ralph C. Huston, Ph.D., of Michigan State College, East Lansing, was chosen as President of the Board.

\* \* \*

A summer outing was held by the Muskegon County Medical Society at the Old Channel Trail Golf Course on Wednesday, August 10. Golf, swimming, baseball, refreshments, and dinner were enjoyed.

\* \* \*

The House of Delegates of the Michigan State Medical Society will convene on Monday, September 19, 1938, at 9:00 a. m.

All members of the State Society are welcome and are urged to attend this most important meeting.

\* \* \*

Hotel reservations should be obtained early, if you are planning to attend the 1938 Detroit convention of the Michigan State Medical Society. A registration of 2,000 physicians is expected.

Remember the dates: September 20, 21, 22, 1938; the place: Book-Cadillac Hotel, Detroit.

\* \* \*

"Save an order for the M.S.M.S. advertiser and exhibitor" is a slogan that should be heeded by the 4,000 members of the State Society. These friends help to maintain two important features of the State Society—the Annual Meeting, and THE JOURNAL.

\* \* \*

The American Association of Railway Surgeons will hold its 23rd annual meeting at the Palmer House, Chicago, September 19 to 23. All members of the M.S.M.S. are invited to attend this meeting. The program may be obtained by writing A. G. Park, A.A.R.S., Palmer House, Chicago.

\* \* \*

A "Preventive Medicine Reunion" will be held at the Book-Cadillac Hotel, Detroit, September 21, 1938, with a luncheon. All those members of the Preventive Medicine Committee during former years are especially invited and urged to attend this luncheon. All others who are interested in preventive medicine are cordially invited to attend.

The speaker will be John Gordon, M.D., of Boston, who has recently spent considerable time in

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\* \* \*

Clare Gates, Dr. P. H., who has been acting as Field Secretary for the Joint Committee on Health Education for several years, recently resigned to accept a position as Director of Public Health Education for the North Dakota Department of Health, Bismarek. Congratulations, Dr. Gates, and full success in your new work.

\* \* \*

The Attorney General of Michigan has requested the Michigan State Medical Society, through the State Board of Registration in Medicine, to develop an article dealing with the evils of marihuana, both mentally and physically, upon human beings.

The invitation of the Attorney General has been accepted by the State Society.

\* \* \*

The Northern Michigan Medical Society was host at a "State Society Night" on July 21, in Petoskey. Talks were given by M.S.M.S. President Henry Cook, Council Chairman P. R. Urmston, Councilor I. W. Greene and Secretary L. Fernald Foster, Councilor B. H. VanLeuven, of Petoskey, presided as President of the Northern Michigan Medical Society.

\* \* \*

County societies are urged to prepare statements and statistics which may be presented by them to supervisors and county poor commissioners in the various counties, to prove that Preventive Medical Procedures, by the early treatment of syphilis, tuberculosis, mental hygiene, et cetera, will save money in the long run by cutting down long-time institutional care.

\* \* \*

A Bureau of Information will be maintained at the Registration Desk, 4th Floor, Book-Cadillac

Hotel, Detroit, on the occasion of the M.S.M.S. Annual Meeting.

Physicians expecting to receive telephone calls should leave the proper information with the hotel operator, so that calls may be relayed by the operator to the Bureau of Information, if necessary.

\* \* \*

Parking: Special rates for parking for members attending the Detroit meeting of the M.S.M.S. have been arranged as follows:

Two Units of the Detroit Garages, Inc., one at Cass and Lafayette, and the north unit at Clifford and Elizabeth, will provide rates as follows:

2 hours—25c	24 hours—\$1.00
4 hours—35c	3 days—\$2.00
10 hours—50c	4 days—\$2.50
18 hours—75c	

\* \* \*

The Second Annual Symposium on Occupational Diseases of the Department of Industrial Medicine of the Northwestern University Medical School will be held on September 26 and 27, 1938, at Thorne Hall on the Chicago Campus.

The program will include papers on industrial disease education, the scope of the occupational disease research problem, traumatic neurosis, the health of the worker in the shop and at home, industrial plant surveys, industrial health and the practicing physician, cardiovascular disease and peripheral vascular disease in the middle aged group of industrial workers.

At a final evening banquet session the subjects will be the responsibility of labor, management, and the community and morbidity and mortality statistics.

\* \* \*

Dr. Carlton B. Pierce, Associate Professor of Roentgenology of the University of Michigan Medical School, has resigned to become director of the Department of Radiology at the Royal Victoria



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Hospital, Montreal, where he will also be associated with the faculty of the Medical School of McGill University. Dr. Pierce was a member of the Detroit Roentgen Ray Society, and also the Michigan Association of Roentgenologists.

\* \* \*

November 8, 1938, is General Election Day. No more important day in the life of a physician can be registered—especially this year, and in view of the momentous and serious problems which are being thrown out from the national capitol.

Vote on Election Day for friends of Medicine. See that your wife and members of your family vote. Urge your patients to vote for U. S. Congressmen and State Senators and Representatives who will insure them a high quality of medical service.

\* \* \*

Dr. Wm. M. Donald of 938 David Whitney Bldg., Detroit, is compiling a short history of the Northern Tri-State Medical Association, now almost seventy years of age.

The founders and early officers of this hustling and aggressive organization seem to have been careless in preserving the official documents incident to the creation and development of such a society, and, hence, the historian's task is a heavy one.

Any information relative to the Society above mentioned during the period between 1870 and 1885 will be highly appreciated by Dr. Donald.

\* \* \*

The M.S.M.S. Maternal Health Committee announces a get-together luncheon on Wednesday, September 21, in the Book-Cadillac Hotel, Detroit, at 12:30 p. m., for all members, past and present, of the State Society's and of county societies' Maternal Health Committees.

Joseph L. Baer, M.D., of Chicago, Clinical Professor, Department of Gynecology and Obstetrics at Rush Medical College, a fluent speaker, of international reputation, will address the group on "The Opportunities and Responsibilities of Committees on Maternal Health of County Medical Societies."

\* \* \*

The Michigan Branch of the American Medical Women's Association will hold their annual meeting, which will be both Scientific and Social, September 19 to 22 in conjunction with the Michigan State Medical Society.

Among those taking part in the Program are Dr. Mary Margaret Frazer, president of the Michigan Branch and vice president of the National A.M.W.A., who will give a résumé of the meeting held in San Francisco in June, and Dr. Bertha Van Hoosen of Chicago, former president of the National Association, who will give a talk and moving picture on a gynecological subject. The Blackwell Medical Society, through its president, Dr. Francis Ford, has arranged a dinner honoring the State Medical Women. The members of the A.M.W.A. will be notified later of a completed program. All medical women of Michigan are invited to attend this meeting. Please notify Dr. Thelma Wygant, 651 Fisher Building, Detroit, or Dr. Mary Margaret Frazer, President, 76 W. Adams Avenue, Detroit.

\* \* \*

*Crippled and Afflicted Child Commitments, for July, 1938:*

Crippled Child: Total cases, 470, of which 172 went to University Hospital; 298 to miscellaneous hospitals. From Wayne County, of the above, 16 went to University Hospital; 80 to miscellaneous hospitals; total 96.

Afflicted Child: Total cases, 2,172, of which 331 went to University Hospital; 1,841 went to miscellaneous hospitals. From Wayne County, of the above, 34 went to University Hospital; 550 went to miscellaneous hospitals; total 584.



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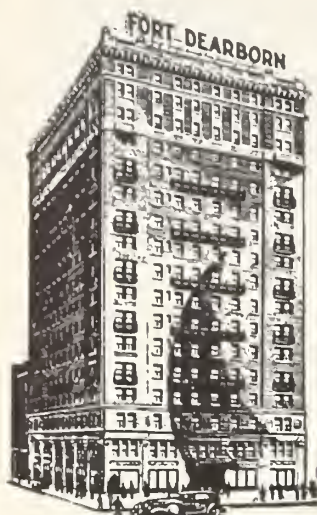
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## American Board of Internal Medicine, Inc.

Written examinations for certification by the American Board of Internal Medicine will be held in various parts of the United States on Monday October 17, 1938, and on Monday, February 20, 1939.

Formal application must be received by the Secretary before September 15, 1938, for the October, 1938, examination, and on or before January 1 for the February 1939 examination.

Application forms may be obtained from William S. Middleton, M.D., Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin.

\* \* \*

## Interstate Postgraduate Medical Association

The International Assembly of the Interstate Postgraduate Medical Association of North America will be held in the Public Auditorium of Philadelphia, Pennsylvania, October 31, November 1, 2, 3 and 4. Pre-assembly and post-assembly clinics will be conducted in the Philadelphia hospitals the Saturdays previous and following the Assembly.

It is the aim of the International Assemblies to present to the profession the approved advancement of medical science and research, not unmindful of the practical side of medical study. To this end, diagnostic clinics, orations, symposia and discussions are offered by leading teachers and clinicians.

The high standing of the medical profession, combined with the usual clinical facilities of its great hospitals and excellent hotel accommodations, make Philadelphia an ideal city in which to hold the Assembly.

The Association through its officers and members of the program committee extends a very cordial invitation to all physicians in good standing in their State and Provincial Medical Societies to attend the Assembly. An unusual clinical and didactic program, including all branches of medicine and surgery and the specialties, has been arranged by the program committee.

The members of the profession are urged to bring their ladies with them as a very excellent program is being arranged for their benefit by the ladies' committee. Philadelphia has many places of historic and other interests, which will make this year's program especially attractive to them.

In coöperation with the Philadelphia County Medical Society, the College of Physicians of Philadelphia, and the Pennsylvania State Medical Society, and with the active support of the Philadelphia Chamber of Commerce and the Convention and Tourist Bureau, a most excellent opportunity for an intensive week of postgraduate medical instruction is offered by a very large group of acknowledged leaders in the profession.

With a great deal of pride and satisfaction, we call your attention to the list of distinguished teachers and clinicians who are to take part on the program and whose names appear on page 844 of the advertising section of this JOURNAL.

Registration fee of \$5.00 admits all members of the profession in good standing.

Officers of the Association are:

Dr. Elliott P. Joslin, *President*, Boston, Mass.; Dr. George W. Crile, *Chairman Program Committee*, Cleveland, Ohio, and Dr. William B. Peck, *Managing-Director*, Freeport, Ill.

\* \* \*

## University of Michigan Medical Reunion

A reunion of the University of Michigan Medical School, and of the former staff members and internes of the University Hospital is to be held in

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Ann Arbor on September 29 and 30 and October 1, 1938.

There will be a two-day scientific program in which the following will participate: Dr. Reuben Peterson, Professor Emeritus of Obstetrics and Gynecology: Landmarks in the History of the University of Michigan Medical School and Its Hospital; Dr. Cyrus C. Sturgis, Professor of Internal Medicine: A Résumé of Eleven Years' Experience in Hematology at the Simpson Memorial Institute; Dr. Donald D. Van Slyke, Rockefeller Institute for Medical Research, New York City: The Physiology of Renal Excretion; Dr. Norman F. Miller, Professor of Obstetrics and Gynecology: Common Lesions of the Cervix; Dr. Ward J. MacNeal, Professor of Pathology and Bacteriology, New York Postgraduate Medical School, Columbia University, New York City: Bacteriophages as Aids in Dealing with Infections; Dr. Carl E. Badgley, Professor of Surgery: A Study of the Causes and Methods of Prevention of Non-union of Fractures of the Shaft of the Long Bones; Dr. Walter Bauer, Associate Professor of Medicine, Harvard University Medical School, Boston: The Physiology of Normal Joints and its Relation to Joint Disease; Dr. Bradley M. Patten, Professor of Anatomy: The First Heart Beats and the Beginning of the Circulation of Blood as Shown by Micro-moving Pictures of Living Embryos; Dr. Carl V. Weller, Professor of Pathology: The Intrinsic Factor in the Etiology of Malignancy: Inheritance of Retinoblastoma; Dr. Joseph Brenne-  
mann, Professor of Pediatrics, The School of Medicine of the Division of Biological Sciences, University of Chicago: Abdominal Pain in Children; Dr. Hugo A. Freund, Professor of Clinical Medicine, Wayne University College of Medicine, Detroit: Renal Ischemia and Vascular Hypertension Associated with Coarctation of the Aorta. Case Reports;

Dr. Max M. Peet, Professor of Surgery: Results of Splanchnicectomy for Hypertension.

Dr. Hugh Cabot, former Dean of the Medical School, Professor of Surgery at the University of Minnesota Graduate School of Medicine, The Mayo Foundation, Rochester, Minnesota: Intravenous Urography: Its Place in General Medical and Surgical Diagnosis; Dr. Francis E. Sencar, Professor of Dermatology, University of Illinois College of Medicine, Chicago: The Serologic Diagnosis of Syphilis; Dr. Frederick A. Collier, Professor of Surgery: Physiology and Chemistry in Surgery; Dr. Frank N. Wilson, Professor of Internal Medicine: The Differential Diagnosis of Coronary Occlusion; Dr. Charles W. Edmunds, Professor of Materia Medica and Therapeutics: The Problem of Drug Addiction; Dr. Warren T. Vaughan, Richmond, Virginia: Tissue Tension Studies in Clinical Allergy and Experimental Anaphylaxis; Dr. James B. Herrick, Professor Emeritus of Medicine, Rush Medical College, University of Chicago: Acute Endocarditis; Dr. Louis H. Newburgh, Professor of Clinical Investigation in the Department of Internal Medicine: A New Interpretation of Diabetes Mellitus in Middle-aged Obese Persons; Dr. Perrin H. Long, Associate Professor of Medicine, Johns Hopkins University Medical School, Baltimore, Maryland: Further Observations upon the Experimental and Clinical Use of Sulfanilamide; Dr. Frederic M. Loomis, Oakland, California: The Third Component: The Relationship between Them; Dr. H. Winnett Orr, Lincoln, Nebraska: Methods for the Prevention and Cure of Septicemia following Injuries and Surgical Operations; Dr. Udo J. Wile, Professor of Dermatology and Syphilology: Sex Hormone Studies in Acne. The Urinary Excretion of Androgenic and Estrogenic Substances. Clinic on Lymphoblastomas.

In addition to these clinical talks, there is to be

## *To My Friends In the Medical Profession—*

As the Gastro-Photot (Stomach Camera) is now taking most of my efforts in its National Distribution and Sales, I do not have the time for the treasured personal contacts with you that I formerly enjoyed. However, I wish to utilize this space to sincerely thank all of you who have been so marvelously good to me in the past.

If you were in San Francisco at the National Meeting I am sure that you stopped to say "hello." However, if you were not in attendance be sure to see me at St. Louis in 1939.

*Nelson Williams*

P.S. The office of the Physiotherapy Equipment Company is still controlled by me, at the same address, 12148 Woodward Avenue, To. 8-8035, Detroit.



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**GYNECOLOGY**—Two Weeks Course starting October 10th. Gynecological Pathology by Dr. Schiller starting October 24th.

**OBSTETRICS**—Two Weeks Intensive Course starting October 24th. Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course every week; Intensive Formal Course starting October 3rd.

**DERMATOLOGY AND SYPHILOLOGY**—Two Weeks Special Course starting September 19th. Clinical Course starting every week.

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a banquet held at the Intramural Sports Building at which Dr. Frederick G. Novy, Dean Emeritus of the Medical School, is to be speaker. On September 29 there will be a luncheon at which a round table discussion on the subject of Arthritis will be conducted by Dr. Walter Bauer and Dr. Richard H. Freyberg, Assistant Professor of Internal Medicine. At the luncheon on September 30 there will be a symposium on the subject of poliomyelitis. The reunion will be concluded on October 1 at the opening Convocation of the Medical School, at which time Dr. Peyton Rous of the Rockefeller Institute for Medical Research will be the speaker. On the afternoon of October 1 the football game between the University of Michigan and Michigan State College will be held.

A large attendance is expected. A series of interesting exhibits is being planned. There is to be entertainment for the wives and women guests and a general party is to be held at the Washtenaw Country Club on the evening of September 30.

### **Among Our Contributors**

**Dr. L. Byron Ashley** is a graduate of the Detroit College of Medicine in 1914 and is Associate Surgeon on the staff of Harper Hospital, Detroit.

\* \* \*

**Dr. Clark D. Brooks** is a graduate of the Detroit College of Medicine, 1905, and at the present is Surgeon on the staff of Harper Hospital, Detroit.

\* \* \*

**Dr. William R. Clinton** is a graduate of the Detroit College of Medicine in 1911 and is Surgeon on the staff of Harper Hospital, Detroit.

\* \* \*

**Dr. Frederick Christopher** was graduated from the Johns Hopkins Medical School in 1915. At present, he is Associate Professor of Surgery at the Northwestern University Medical School and Chief Surgeon at the Evanston Hospital, Evanston, Illinois.

\* \* \*

**Dr. Charles Gitlin** was graduated from the University of Michigan Medical School in 1923. His internship training was received at the Highland Park General Hospital. For two years thereafter he was assistant to Dr. Frank Suggs. In 1927 he pursued post-graduate course at the Laboratory of Surgical Technique and Augustana Hospital, Chicago, Illinois. Dr. Gitlin is a member of the surgical staff, out-patient division of the Highland Park General Hospital.

\* \* \*

**Dr. William A. Lange** attended the University of Minnesota, where he received the degree of B.S., also B.A., and in 1934, M.D. He spent his internship at Receiving Hospital in Detroit, and at present is on the staff of Grace, Harper and Receiving Hospitals in Detroit. His practice is confined to plastic surgery.

## IN MEMORIAM

James H. Greenwood, M.D.

Dr. J. H. Greenwood, of Detroit, died at his home on July 24. Dr. Greenwood was born in 1864 in Ontario. His early education was acquired at Ridgeway, Ontario, high school, following which he spent several years as a public school teacher. He entered upon the study of medicine at the Detroit College of Medicine, where he graduated in 1894. Dr. Greenwood was in general practice up to the time of his death. He is survived by his wife, Bessie; two sisters, Mrs. Albert Campbell, of Vancouver, and Mrs. William Gilbert, of Elkhorn, Manitoba; four brothers, Samuel, of Vancouver, Ben H., of Winnipeg, William, of Chatham, and Chalmers, of Stratford, Ontario. Dr. Greenwood was a member of the Wayne County Medical Society, the Michigan State Medical Society and the American Medical Association.

Richard Hayward Morgan, M.D.

Dr. Richard Hayward Morgan, of Detroit, died on July 10, 1938. Dr. Morgan was born June 28, 1881, in Albert Lea, Minnesota. He attended public school in Minneapolis and in 1908 he was graduated from the University of Michigan Medical School. He entered private practice in Detroit and in 1910 he became resident physician at Castle Springs Sanitarium in Arizona for two years. From 1912 to 1917 he was on the medical staff of the Equitable Life Insurance Company in Chicago. The ten years following this, he served on the staff of Mount McGregor Sanitarium in New York, specializing in diseases of the chest. In 1927 he took charge of the Extramural Consultation Service in Tuberculosis at Herman Kiefer Hospital. Dr. Morgan was also on the visiting staff of Harper Hospital and the Detroit Tuberculosis Sanitarium as well as maintaining his private practice. He was a member of the Wayne County, Michigan State and American Medical Associations, the National Tuberculosis Society and a former president of the Trudeau Society of Michigan. He leaves his wife, the former Eleanor Gillett of Bay City.

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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**PRACTICAL OTOTOLOGY, RHINOLOGY AND LARYNGOLOGY.** By Adam Edward Schlanser, M.D., Colonel, Medical Corps, United States Army, Chief of the Eye, Ear, Nose and Throat Service, Letterman General Hospital, San Francisco, California; Former Director of the Department of Ophthalmology and Otorhinolaryngology, Army Medical School; and Chief of the Eye, Ear, Nose and Throat Section, Walter Reed General Hospital, Washington, D. C. Octavo, 315 pages, illustrated with 81 engravings. Cloth, \$4.50, net. Philadelphia: Lea & Febiger, 1938.

This work emphasizes the clinical aspect of the subject. Only the essentials of otology, rhinology and laryngology have been included in the work. It is based on a large experience in the Medical Corps of the United States Army. Being brief, it is essentially a book for the general practitioner. It discusses special complications which he is likely to encounter. The text is well illustrated.

**PNEUMONIA AND SERUM THERAPY:** By Frederick T. Lord, M.D., Clinical Professor of Medicine, Emeritus, Harvard Medical School; Member of the Board of Consultation, Massachusetts General Hospital; Member of the Massachusetts Advisory Committee on Pneumonia, 1931-1935; and Roderick Heffron, M.D., Field Director, Pneumonia Study and Service, Massachusetts Department of Public Health, 1931-1935. Revised edition of Lobar Pneumonia and Serum Therapy. New York: The Commonwealth Fund, London: Humphrey Milford: Oxford University Press, 1938. Price, \$1.00.

This work is particularly devoted to the treatment of lobar pneumonia by means of serum. In it is

discussed the use of anti-pneumococcic serum with special attention to clinical diagnosis, the selection of cases for treatment and identification of pneumococcus type. The author goes into detail in regard to technic of administration of the serum and he stresses the precautions to be observed in its use with possible reactions and their treatment.

**ESSENTIALS OF PSYCHIATRY.** By George W. Henry, M.D., Associate Professor of Psychiatry, Cornell University Medical College, New York, Attending Psychiatrist, The New York Hospital, New York. Third edition. Baltimore: The Williams and Wilkins Company, 1938. Price \$5.00.

The necessity of treating the patient as a whole as well as his disease has been stressed to such a degree that the present work will be welcomed by those whose practice is concerned with the broad field of medicine or of surgery, as the case may be. There has been a long felt want for a work which gives the essentials of psychiatry in a plain way with the minimum of technical phraseology. In fact, a third edition within twelve years is evidence of the demand. The general practitioner will find here the information to help him handle incipient mental cases intelligently. While of value to the medical student and the non-specialist, the psychiatrist may find a work of fewer than five hundred pages somewhat elementary.

**MEDICAL WRITING, THE TECHNIC AND THE ART.** By Morris Fishbein, M.D., Editor, The Journal of the American Medical Association, with the assistance of Jewel Whelan, Assistant to the Editor. Press of American Medical Association, Chicago, 1938.

No book is of more value to a physician who is interested in transmitting his thoughts and observations to his colleagues than one on the art of preparing manuscripts for publication. This work by Dr. Fishbein is more than a revision of the earlier work by Fishbein and Simmons. Many sections are completely rewritten, and the extensive experience of the various editorial offices of the American Medical Association journals is incorporated. The technic of manuscript organization and preparation, suggestions on the preparation of illustrations and sections on grammar, spelling and abbreviation make up much of the subject matter. Often faulty and correct modes of expression are contrasted. Writers, particularly those who intend submitting articles to the Journal of the American Medical Association and the associated publications, will find the work a real help.

**MEDICAL STATE BOARD QUESTIONS AND ANSWERS:** By H. Max Goepf, M.D., formerly Professor of Clinical Medicine in the Graduate School of Medicine, Jefferson Medical College; formerly Assistant Visiting Physician, Philadelphia General Hospital; formerly Professor of Medicine, Woman's Medical College of Pennsylvania. Seventh Edition, Revised. 644 pages. Philadelphia and London: W. B. Saunders Company, 1938. Cloth, \$5.50 net.

The concise answers to a multitude of questions on the basic sciences and clinical specialties, which have been culled from examinations of the National and several State Boards, are designed to aid the student in his preparation for these examinations. This new edition has been revised to include questions on the newer developments of medical science as well as to exclude obsolete material. Representative questions and answers cover the following fields: anatomy, physiology, physiologic chemistry, pathology, bacteriology, materia-medica and therapeutics, practice of medicine, surgery, obstetrics, gynecology, hygiene and medical jurisprudence.

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# THE JOURNAL

OF THE

*Michigan State Medical Society*

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 37

OCTOBER, 1938

No. 10

## PROBLEMS OF MEDICAL CARE FACING THE MEDICAL PROFESSION\*

HENRY COOK, M.D.

FLINT, MICHIGAN

Speaking tonight as your retiring President, after having served for nearly eighteen years as a member of your profession in the ranks, and twelve years actively connected with your organization in an official capacity, either as a Councilor, Chairman of the Council, President-Elect, or President, you must realize that there have been many lessons learned and many impressions made which that retiring officer would like to impart to each member of the profession.

There have been many times during this experience when one is reminded of the story of Daniel Boone when he was asked if he was ever lost in the woods. "No, I never got lost," said Daniel, "but I was once bewildered for three days." Many times there have arisen perplexing problems which I have seen your officers seek to solve in the interest of the medical profession.

We are very fortunate, as a profession, in having the assurance that the welfare of the public goes hand in hand with that of the medical profession. These problems have been especially difficult and important since 1929. They have been largely economic in character. Many times there have been evidences of the medical profession seeking, through its organization, to solve the medical needs of the people in various communities. There has been the problem of medical care of the indigent and the near indigent. There has also been the problem of medical care of those who are able to purchase the care they need. I believe our profession has sought, and in most instances met, the problem of medical care of the group last mentioned.

We have given considerable attention, realizing that it was our responsibility, to

keep the cost of medical service down within the means of those requiring it. It goes without saying, however, that there are many expenses attached to sickness which, while they can be influenced by our profession, we are unable to completely eliminate. The doctor's bill is only one-third of the cost. I believe it can be said, without fear of contradiction, that where influence of the medical profession has been strongest in furnishing medical care to the indigent, there has the service been most efficiently administered, of the highest quality and more broadly distributed. Wherever the costs have been higher it has been because the services have been greater. Our committees of the State Society have developed scientific programs also of improving medical care to all. This has included programs for the eradication of syphilis, immunization to disease, case finding, prevention and care of tuberculosis, a program for the prevention and care of cancer, developing of programs for postgraduate education of all the medical profession, actively cooperating in the maternal health program of our state, assisting in the planning by government, through its officials, including our state

\*President's address delivered at the General Session at Detroit, September 21, 1938.



health officer, to the end that the highest quality of medical service be available to all. This is an excellent background upon which to build. We cannot rest on our oars, we must push forward. Our profession is in an enviable position—our opportunity for future service is unlimited. Our State Health Commissioner has said, and I know he honestly believes, that the success of his work depends upon the coöperation of our profession. Governor Murphy is extremely interested in making available the highest quality of medical service to all the people, and has stated that it shall be done through a program approved of and coöperated in by the medical profession of our state. He has repeatedly stated that it can only be done with our help.

The House of Delegates of the American Medical Association has taken very significant action in this connection. There have been many organizations and foundations which have, from time to time, interested themselves in the problems of health and medical service to all of the people. Regardless of what their motives may have been, the effect has been to center attention on the problem of supplying medical service to our people. The medical profession has been cognizant of these demands and has reacted in different manners. Some have felt that these organizations have an ulterior motive. Some of us realized that we must give recognition to their demands.

Last night the action of the House of Delegates of the American Medical Association in San Francisco and the more recent action of the Special Session of the House of Delegates in Chicago was called to your attention. I shall endeavor, at this time, to interpret this action to you as the Michigan delegates and those who were in Chicago understand it.

The House of Delegates unanimously adopted a resolution which approved of the expansion of public health services as outlined by the Technical Committee, these plans and programs being developed on an economical basis by local health organizations coöperating with the local medical profession. They approved the expansion of hospital facilities where needed; calling attention to the need of better and more complete use of the facilities now in existence. They approved of and insisted upon complete medical care for the medically indigent, being willing to assume their share

of the responsibility together with the balance of the community, feeling that government should make funds available where the local and state communities are unable to finance the needed care. They approved of voluntary health insurance on a cash indemnity basis; they approved of group hospitalization and sickness insurance against loss of wages during sickness. They instructed the Speaker of the House of Delegates to appoint a committee of seven to confer with the proper federal representatives to facilitate these objectives.

My interpretation of this is that the medical profession of this country has expressed through its House of Delegates in Special Session its willingness to fully meet the responsibility of the care of the sick of this country, feeling that it should be done on a common-sense basis.

The medical profession believes, however, that this can best be accomplished by coöperation jointly between the medical profession and governmental officials who are charged with that responsibility.

Through the appointment of this committee of seven, the profession demonstrated its willingness to coöperate; in fact, it is my interpretation of that session in Chicago, which I attended, that they are not only willing, but demanding that it be done. I think it is very significant that the House of Delegates ordered that a committee be appointed of practicing doctors to confer with the governmental agencies.

Now, let us consider our problems in Michigan. There are many unsolved problems in medicine in Michigan, and after these problems are solved there will still be many more that develop to intrigue the profession of the future. It is in the solution of these problems that now face us that the medical profession has its greatest opportunity to maintain its traditions and standing, as in the past. In the meeting of these problems we gain strength.

Let us not forget that the tradition of our profession has been that of service. It is true that the laborer is worthy of his hire. We need have no fear of the financial return if we meet our responsibility. I wish to call your attention to the fact that the chain is no stronger than its weakest link, and it is just as essential that the county medical society shall be actively studying and supporting the parent organization of the state society as it is for the state society



to have a program. It is important, if we have a program, that we be doing something about it. The Socialist Party in Germany had an excellent program, far better than Hitler's, but Hitler seized his opportunity and did something about it. The program of your state organization will never be effective unless it is integrated through the county society and the large majority of the individual members.

Let us consider some of the problems that need our attention at this time. There have been great advances in the quality of medical service supplied to the indigent, and in the breadth of distribution. However, studies show that in many localities, for various reasons, this is not as satisfactory as it should be. In some instances the attitude of those who have the responsibility of distributing the funds and approving those who shall receive medical relief, is not what it should be. Fortunately, we can prove that the best quality of medical service is not the most expensive.

The great majority of the medical profession today feel that hospital insurance will remove considerable of the burden of sickness from a large number of our population. There are some differences of opinion between the medical profession and the hospital, but this can be adjusted. We must recognize that there are certain facilities, the need of which has developed through scientific advance in medicine, which must be made more freely available to all. The x-ray and laboratory services must be more available if we expect to properly handle the prevention and treatment of many diseases. There are certain localities in our state where there is too much delay in obtaining their benefits, and the cost attached thereto is preventing their use. A careful study of these needs must be made and conditions improved. The building of buildings, establishing of laboratories, and other facilities where they are not needed, would be a waste of funds and would make such a program unpopular. Buildings without properly trained technicians under the supervision of proper physicians, will render little service. Proper programs of making these services available are equally essential. Therefore, the development and location of these facilities must be made after careful study, taking into consideration improvement of facilities now already in existence. Groups of properly trained members of the medical

profession should associate themselves together in order that greater ease and facility for diagnosis be developed. There is no reason why private practicing physicians cannot form their own groups for diagnosis.

There are many members of our medical profession today who feel that a complete examination, where all of the laboratory facilities are used and specialists working together, costs more than the patient can pay, not saying that the service is not worth the cost. Attention to this should be given in the various communities.

The county medical societies should have a very important part in the development of public health programs in the county, regardless of what the program is. It is essential that the health officer shall recognize that his work will never be what it should be unless the profession of his community has a part in the planning and in the effecting of his public health program. Any health officer who does not seek the coöperation of the medical profession in his community has not the proper vision. Any profession which is not willing to coöperate in a fair program of public health is subject to severe criticism. However, I believe this is rare. The medical profession should interest itself in having committees, in its organization, to study the problems of public health, which include the health of school children and children of pre-school age. This must include a program of lay education. This program of public health should not include free service to those who can pay, because we are thereby teaching them to depend upon some one else for their services rather than teaching them what service they need and where to obtain it.

It is true that the death rate from tuberculosis has been reduced in this state from over 100 per 100,000 to 43 per 100,000. This is not low enough. If we have been able to reduce it to that degree, with the proper use of the facilities now known, improvement of hospitalization and care, development of programs for the proper employment of arrested cases in order that they shall not relapse after discharge from hospitals, improvement in case finding, more thorough study of the contacts, having in mind finding the source of infection and its elimination, there is no reason why this figure of 43 per 100,000 should not be reduced to nearly zero. It is our responsibility to give serious attention to the prob-



lem of tuberculosis in our own community. Tuberculosis is already costing too much and by such a program the cost would be reduced.

In our state we have an excellent program of maternal health. There is in existence a Maternal Health Committee in practically every county society. These committees should be more active.

The program of syphilis control in our state is deserving of greater support.

There is altogether too little interest given by our profession, as individuals, in the problem of cancer. It is true there are programs of lay education now in operation. Some of the committees of our state society feel that either the profession is not becoming as informed as the public, or they are not as interested as they should be. The program of activity of our profession must keep abreast with programs of lay education.

There is today some demand, at least, for a program of health insurance. It is my personal opinion that a program as outlined, effectively carried out by our profession, is of far greater importance and value than any un-American, untried scheme of distribution, and will receive the heartiest coöperation from all those agencies interested in health who are outside the medical profession, and is our greatest defense against having something unsound being imposed upon the public and the profession. I have no fear of these; if we do

our job there is no doubt but what we will meet our responsibility. Our interest in this, and the attitude of our profession was well known at the Health Conference recently held in Lansing. We were told at that conference, by a well known labor leader in this state, that labor had no desire to impose anything unfair upon the medical profession, that our profession should be adequately paid for its services in order that the highest type of medical service would be maintained; in fact he said he did not object to our having a monopoly upon medical care, but with that there was a responsibility which we must meet. I feel that is not unreasonable. I am sure we have nothing to fear from labor.

We must give attention to the problems of the more unfortunate because we cannot shirk our public responsibility to be good citizens. We have a responsibility to the public, to ourselves, to our profession, and to those members of the profession who come after us. The profession must be leaders in medical problems, since we have the knowledge and training required.

I am sure that under the leadership of Dr. Luce, your Council, and the officers of your county societies, that you will meet these outlined responsibilities. These responsibilities are coupled with great opportunities. Our profession would thereby maintain the position which it has always held in the past and need have no fear for the future.

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### Physicians' Privilege

WASHINGTON: "Uncle Sam's tax collectors have invoked a little known provision of the 1926 law that threatens to violate the sanctity of relationship between physician and patient, lawyer and client, minister and church-goer. To the knowledge of the Capital's medico-legal experts it has never been so utilized before.

"The case now provoking professional howls involved a man who transferred property within two years of death, thereby arousing official suspicion that the transactions were designed to cheat the Treasury.

"An internal revenue agent moved in on the man's doctor with the demand that the latter turn over the complete medical file in the case—possible evidence that the taxpayer had distributed his for-

tune in anticipation of death. When both the physician and his lawyer protested that such procedure was outrageous and illegal, the Government man cited Section 820, Paragraph b, Title 111 of the 1926 law.

"That provides that 'whoever' withholds any record with respect to a decedent's estate shall be liable to a fine of \$500. The 'whoever,' under strict interpretation, would include a priest or a lawyer.

"Most judges ordinarily hold that such exchanges are confidential, but the very application of the law forces defendants to apply to the court for refuge, with consequent expense, trouble and notoriety. It's another score which these two professions—lawyers and physicians—hold against New Deal commissars."

# THE EARLY TREATMENT OF MENTAL DISORDERS

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We are not very far removed in point of time from the days of the asylum, and even from the days when considerable stock was taken in the demoniac nature of mental disorder. In the asylum days a wall often literally existed between the asylum and the community. The asylum doctors received little recognition from their brethren in the community, and the physicians in the community in turn fancied that they had very little to do with the subject of mental disease. Mental disorder, in other words, was thought of almost entirely in terms of committable "insanity," or, as it was sometimes called in those days, "lunacy." This attitude was fostered by the extremely light touch given to the presentation of the subject of psychiatry in the medical schools. There were a few casual lectures dealing with such general topics as "mania" and "dementia," frequently without any clinical demonstrations whatever, and it is therefore readily understandable why the average graduate of a medical school even a quarter of a century ago looked upon psychiatry as a specialty so far removed from the sphere of general medicine as to be entirely beyond his ken or interest. The tremendous rise of specialization in medicine, with its departmentalization of the human being, exerted a similar untoward effect upon a grasp of the principles of psychiatry. The humorous definition of a specialist as "one who knows more and more about less and less" has been all too frequently applicable. The cardiologist or gastro-enterologist tended to look upon the patient as a heart or a digestive tract surrounded by other tissues, while all too frequently disorders of other organ systems, and, what is fully as bad, disorders of the total personality, were entirely overlooked.

## Psychiatric Viewpoint in General Practice

The successful general practitioner, whether or not he realized or professed it, had a psychiatric viewpoint, as we should term it today. He realized, even if the specialist did not, that he was dealing with a human being, an individual who not only possessed certain organs, but who in addition was a social animal, an organism functioning in an environment made up not only of physical objects and their relations, but of other human beings, a person with hopes, desires, conflicts and frustrations. He was a recipient of confidences, knew the problems

which faced his patient and recognized their importance in the development and treatment of illness. This is, in essence, the attitude of the psychiatrist today. He is interested in far more than merely those patients who require care in a mental hospital; he is interested in the total personality, and so finds himself closely allied in viewpoint with the general practitioner, although interested as well, of course, in the findings of all the specialties as they affect his patient. The general practitioner, in the last analysis, is the man who is on the firing line. He is the man to whom the patient with personality disorders comes first, and what is done for that patient later on, whether it be home care, or a consultation with a psychiatrist, or treatment in a mental hospital, is for practical purposes dictated by him. I have already spoken of the concept of the unity of the organism. Too often in the past we have found that there existed in the minds of medical men, as well as of the laity, some vague notion of a sharp differentiation between body and mind, some of this, of course, being a survival of the old theological notions of the separation of body and soul. The phrenologists a hundred years ago thought they had isolated certain portions of the brain in which special functions of the mind resided, so clear was their notion of this division between functions of mind and the body. Of course it is recognized today that the mind is not something entirely apart from the body, and that there does not exist somewhere in the brain a separate and independent entity which directs the activities of the body, a notion which was fostered by the old functional psychology.



### Bodily Changes from Emotion

The work of Cannon, Coghill, Dunbar, and others, on the bodily changes resulting from emotional disturbances, has given a death blow to this idea of complete separation. It should be mentioned, of course, that hysteria and some of the other psychoneuroses had long been recognized as being due to mental influences, although their mechanisms had been almost entirely buried until Freud's studies cast such light upon the unconscious activities. As we look back it seems strange that it should have required the painstaking work of Cannon and other leaders in this field to bring to the general consciousness of the medical profession the close relationship between emotional changes and bodily function, when in everyday life we meet numberless evidences of this relationship. The effects of fright upon the gastro-intestinal tract and upon the activity of the sweat glands, for example, the effect of embarrassment upon the capillaries of the skin, and so on, are matters of common knowledge. That the converse is equally true should require little demonstration even in everyday life, and is, of course, a matter of common experience to the general practitioner. Anyone who has ever had a moderately severe coryza will realize, if he introspects, the fact that his emotional tone was quite decidedly changed by what was a comparatively slight physical disorder. The existence of such phenomena as febrile delirium merely emphasizes the truth of the statement that no physical disorder is without its emotional concomitants. Life after all is a continuing process of adjustment to the environment; what we choose to call "mental" represents the reaction of the individual as a whole to his environment. In dealing with mental phenomena, therefore, the environmental factors and the somatic state of the individual must always be considered; the mind does not work in a vacuum.

### Toxic Infectious Group of Mental Diseases

This preliminary discussion leads us to a consideration of a group of mental disorders in which the physical groundwork is relatively obvious; I refer to the so-called toxic-infectious group of mental diseases. Delirious reactions of one kind or another are perhaps the most common type of mental disorder with which the general practitioner

has to deal, occurring as they do rather frequently in the course of febrile disturbances. They may also be found in the course of exhausting chronic diseases such as uremia and tuberculosis, in malnutrition, pellagra, and so on, and may be due to exogenous toxins such as alcohol, lead, morphine, barbiturates, and others. In the case of infections the degree of delirium is not especially correlated with the degree of rise of temperature. Some individuals remain entirely clear even though the temperature is high, whereas in others a very low degree of fever may result in a rather marked delirious reaction. Here again, as in all diseases, we are dealing not with the infection itself, but with the reaction of the entire organism to it. The characteristics of a delirium are clouding of consciousness, with some degree of disorientation; that is, loss of recognition of the patient's relationship to time, place and person. There may be an early restlessness, headache, sensitiveness to light and sound, a feeling of exhaustion, and then dreamlike experiences occurring while the patient is awake. What goes on about the patient is not clearly perceived, that is, the consciousness is clouded, and as a result various misinterpretations are experienced. Later on definite hallucinations, frequently of sight, as well as of hearing, become manifest, and not infrequently there is a rather marked effect of fear. The condition may go on to a rather wild disturbance, a marked restlessness (jactitation), and sometimes coma and death.

### Prognosis Depends Upon Physical Condition

In general it may be said that the prognosis in this type of reaction is good and that it depends to a very large extent upon the progress of the underlying physical disorder. Obviously, in most of these, except the most transient deliria, home care is extremely difficult and a general hospital is usually indicated. All too often, in a general hospital when a delirium supervenes, the attending physician is likely to have an impulse to send the patient immediately to a mental hospital, and this may even be a hospital rule. An impulse of this sort should not readily be obeyed, for several reasons. In the first place, it sometimes happens that the mere physical transportation of the patient from one hospital to another will have an adverse effect upon him. I have person-



ally known of cases in which the later death of the patient could be well attributed to the trip, the patient being transported perhaps in an ordinary automobile, with the attendance, not of nurses, but of police officers. In the second place, the duration of the disorder may be relatively short, in which case the inconvenience, if any, caused to the general hospital will be brief. It must be admitted that there still remain some people in the community by whom admission to a mental hospital is considered a "stigma." Although there is no reason why nursing care of the same high quality as that furnished in the average general hospital cannot be provided in the state hospital, the unfortunate fact remains that in some jurisdictions (Michigan emphatically excepted) it is not, so that the patient may suffer from inferior care as well as "stigma" if transferred. In a way, too, such an immediate transfer is an evasion of responsibility, and springs from the old notion that mental disorder has nothing to do with the rest of medicine. As a matter of fact, many hospitals throughout the country have now developed psychopathic wards in which the necessary physical accoutrements are provided for the proper care of mental disorders arising during the course of general hospitalization. This tendency is one which is decidedly on the increase and should be encouraged. An additional value of such psychopathic wards is that they tend to bring about a closer union of psychiatry with general medicine, a union which is highly desirable from the point of view of the general practitioner, the specialist and the psychiatrist.

#### Avoid Dehydration

As for the care of patients suffering from delirium, good nursing is of course essential. Dehydration is particularly to be avoided, and elimination should be aided. At times blood transfusion is indicated, as is spinal drainage if edema of the brain appears to be developing. Large doses of sedatives in general should be avoided. Hydrotherapy is far preferable wherever it can be used, as it promotes elimination and avoids adding to the intoxication. If mild sedation is needed relatively small doses of sodium amytal or paraldehyde will prove useful. The patient should be prevented from injuring himself; the close attention of nurses should be provided, and in addition a side

board on the bed or even in unusual circumstances a restraining sheet may be necessary. The injuries which the patient may inflict upon himself are, of course, not inflicted with suicidal intent but are more likely to be due to the restlessness and tossing about of the patient, or on occasion an attempt at flight to evade the fearsome hallucinations from which he may be suffering. Finally, in treating cases of this sort close attention will of course be given to the physical disorder which is at the bottom.

#### Mental Disorder and Childbirth

In this connection a few words may be said about the group of mental disorders sometimes noted following childbirth, and sometimes (though incorrectly) referred to as puerperal psychoses. Childbirth, like any other physiological process, may serve as the precipitating factor in a mental disturbance. If infection has occurred a rather typical delirium may ensue. On the other hand, there are noted from time to time classical cases of schizophrenia, or of manic-depressive psychosis, that seem to have been set off by childbirth. The general principles that have been laid down above should, however, be followed and undue haste should not be manifested in sending the patient to a mental hospital. A conservative policy should be followed, and except in extreme cases the patient should at least not be sent to a mental hospital before the time at which she would ordinarily have been discharged from the maternity ward. In cases of this sort it will of course be necessary to wean the infant promptly upon the development of psychotic symptoms, since at times the mother may attempt to injure the child.

#### Psychological Preparation of Surgical Patients

Occasionally a surgical operation is found to precipitate a psychotic outburst, much as childbirth may. If the average surgeon would only devote a little more attention to the psychological preparation of his patient, it is safe to say that a considerable number of these occurrences could be avoided. Many patients suffer from strange misconceptions regarding the procedures about to be undertaken upon them, and at times the fears and misapprehensions burst their bounds. This is especially true of operations on erogenous zones, notably the genitalia, the various orifices and the breast, which are usually heavily charged with emo-



tional value to the patient. The case cited by Dr. William A. White, of the young man about to be operated for hernia who confused the hernia with the testes and being convinced that his virility was about to be impaired by the operation, developed an anxiety state, is illustrative of my point. Much can be done for the patient's mental health by a brief but frank discussion, and by giving him an opportunity to correct his misconceptions and dispel his fears.

### Delirium Tremens

Before we leave the topic of the toxic deliria, a few words concerning one type, namely, delirium tremens, may not be amiss. It is a rather shocking fact that in the United States at large the patient with delirium tremens is looked upon more as a criminal than as a person suffering from a serious illness calling for a high degree of nursing and medical care. In many jurisdictions, patients suffering from delirium tremens are specifically excluded from public psychopathic hospitals, and all too often we find patients of this type thrown into cells in jails and prisons, entirely without supervision except from their jailers. Delirium tremens is a serious condition with a death rate which is substantial, and the sufferer from it is entitled to as good care as any other sick person. It may be added that recognition is dawning that alcoholism, whether or not leading to delirium tremens, is far more a problem for the physician than it is for the criminal court. The general principles relative to support, elimination, the avoidance of dehydration and starvation, apply emphatically to delirium tremens as to the other types of toxic delirium. It is to be hoped that adequate hospital facilities will in the future be made available for patients of this sort.

### The Organic Group

Passing now to a somewhat less familiar group we come to that series of mental disorders which appear to be due to organic changes in the central nervous system. Whether in the nature of neoplasm, inflammation (such as syphilis or encephalitis), or degeneration (the senile and arteriosclerotic group), the general characteristics of this group of disorders are irritability, rather marked fluctuations of emotional tone and mood, decreased efficiency, changes in personality and greater or less disturb-

ance of memory, particularly for more recent events. Whatever the type, an early recognition of the nature of the disorder is highly desirable, notably in the case of general paresis and brain tumor. With the development of ventriculography and encephalography the diagnosis of brain tumor has been to some extent simplified. It is not always easy in the early stages at best, however, and sometimes even when diagnosed the brain surgeon can do but little. Headaches, the tendency to stuporousness and visual disturbances are suggestive of the possibility of brain tumor, and in such an event the brain surgeon should promptly be called in, since the only hope offered in such a case lies in surgery.

### Cerebral Syphilis

Another condition in which early diagnosis is imperative is general paresis, a form of syphilitic involvement of the brain which may not develop for fifteen or twenty years after the initial infection; it is far more frequent in syphilitics who have been inadequately treated or wholly neglected, and constitutes a forceful argument for the early, adequate and persistent treatment of systemic syphilis. Fortunately, the medical profession is giving great attention nowadays to the problem of syphilis, and the campaign has received tremendous impetus through the splendid activity of Surgeon General Thomas H. Parran of the United States Public Health Service. Already the widespread campaign against syphilis which began during the World War has borne fruit in a slight diminution of the incidence of general paresis, and I think it fair to say that the next 20 or 25 years will witness some rather startling added reductions. Furthermore, the past 20 years have given us much hope as to the curability of general paresis, thanks to the discovery by Wagner-Jauregg of malarial therapy. I take a certain amount of pride in being connected with the institution, Saint Elizabeth's Hospital, in Washington, which was the first in this country to adopt malarial therapy in the treatment of general paresis. It may be said in general that the fever therapy of this disease has revolutionized our attitude toward it and has produced a very substantial number of cures and in many other cases marked improvement. In a series studied carefully in Saint Elizabeth's Hospital in 1932,<sup>8</sup> it was found that in those



cases which had been sent to the hospital within six months or less of the manifestation of early symptoms, 80 per cent were improved, whereas in the late cases the percentage ran as low as 37 per cent. The onset of general paresis is often, indeed usually, insidious, and the general practitioner has an excellent opportunity by his alertness to secure early treatment for his patient, and thus materially increase the chances of recovery. I have already spoken of some of the general symptoms which may be expected, such as loss in efficiency, irritability and change in personality. There are certain rather characteristic neurological signs in addition which should be looked for. All too often early cases of general paresis have been passed off as "neurasthenia" or "nervous exhaustion," or something of the sort, whereas early treatment might have altered very materially the outlook of the case. In any physical examination the pupillary reflexes should be tested. This is a procedure which is not at all difficult, but which is frequently highly significant. Irregularity or inequality of the pupils, and particularly the sluggish or absent reaction to light, should arouse suspicion immediately. The same may be said of absent or exaggerated knee-jerks, of tremulousness of the facial muscles and of the tongue, of an inability to stand quietly with the eyes closed. If any of these signs are found a Wassermann of the blood should be taken, a spinal fluid test done, and a thorough neurological study made. The treatment of a case of this sort is far more satisfactory in a hospital, particularly on account of the fact that the patient suffering from malaria must be cared for in a carefully screened room in order to prevent his being a menace to others in the vicinity. A complication in securing early treatment is sometimes found in the fact that the patients in the early stage are not infrequently euphoric and convinced not only that there is nothing the matter with them, but that they are in much better condition than ordinary men. There may be, therefore, some resistance to hospitalization, and occasionally commitment is necessary. On the other hand, I am impressed with the frequency with which such patients who are admitted to hospitals state freely their desire to have treatment, and are willing to go through with the commitment process if that be necessary for admission to the hospital.

### The Arteriosclerotic Group

The early treatment of patients falling in the senile and arteriosclerotic group is not always easy, and calls for a high degree of patience and understanding on the part of the rest of the family. Patients suffering from arteriosclerosis sometimes show a considerable degree of irritability, a tendency to cry easily, failure of memory and of judgment, and not infrequently a moderate degree of depression. These symptoms may even precede and very frequently follow the epileptiform or apoplectiform attacks sometimes seen in cerebral arteriosclerosis. Obviously the prognosis is not especially good and the most that can be expected is to delay somewhat the ultimate outcome by appropriate hygienic measures. Sometimes the patience of the family is entirely exhausted, for the patient may become so irritable as to make attempts to strike those about him, in which case of course commitment is indicated. The symptoms of incipient senility are much more gradual, far less spectacular, but equally trying. The tendencies to reminisce, talk about the "good old days," to be mildly absent-minded and forgetful, are of course familiar symptoms of dotage which are often met in everyday life. So long as they do not progress beyond this point they can be rather readily tolerated. All too frequently, however, as the course of the disease progresses, the patient becomes irritable, suspicious and rather paranoid concerning the motives of his relatives, and sometimes social complications arise. This is especially true in the case of elderly men who, before reaching their second childhood, apparently reach a stage which might be termed "second youth," during which considerable sexual activity may be attempted, especially with young children. Cases of this sort even leading up to homicide, are not unknown, and, of course, call for control preferably by commitment to a mental hospital. We recognize that most cases of this sort are essentially psychiatric problems, even though the patient may not be in the eyes of the criminal law legally "insane." Other patients develop a delusion of being robbed and make frequent complaints concerning this activity which they allege against their relatives. Unfortunately once in a while there is a modicum of truth in these beliefs! It is my personal opinion that less occasion will be given for that delusion in the future with the development of old



age pensions, and with the realization on the part of the family, and perhaps on that of the patient too, that his being sent away will actually mean a decrease in the family income rather than otherwise. Other patients become distinctly confused, especially at night, and wander about the house or even wander away. Sometimes, feeling chilly, they light fires in places not designed for that purpose, in order to keep warm, sometimes thereby endangering the lives of others in the house. This disturbance of the sleep rhythm may be controlled to some extent by sedatives, and some books on psychiatry even mention the possibility of administering a small dose of whisky in warm milk at night as a sedative. The tendency of the disorder is to reduce the patient to a vegetative level, with incontinence and confinement to bed. The indications for commitment in the case of senile patients are almost entirely social, depending on what the resources and the willingness of the family are. The commitment of an elderly person to a mental hospital should always be a matter of serious consideration and deliberation. The uprooting of such a patient from his home into an institutional atmosphere all too frequently sets him on a downward path and results in an early death. Commitment therefore should be recommended only with considerable hesitation and when clearly the facilities of the family are insufficient to give adequate protection to the patient or to those about him. In general, resistiveness, marked confusion and restlessness, untidy habits, and sexual offenses may be looked upon as constituting indications for hospital care. In some instances the patient can be cared for at home for a considerable period if a conservator is appointed for his property; such patients not infrequently exhibit extremely poor judgment and fall easy victims to sharpers, hence this suggestion.

### Organic and Functional

For purposes of classification the textbooks of psychiatry usually divide the mental disorders into two general groups, namely, the organic, which we have already considered briefly, and the so-called "functional." The latter term is a dangerous one, and tends to deceive the user into thinking that he has explained something, whereas he has merely said that he knows of no definite organic basis. It is more nearly

proper to speak of psychogenic disorders, that is, disturbances which are primarily emotional rather than primarily based upon physical dysfunction, although it should always be borne in mind that in the psychogenic disorders we very frequently, and indeed almost always, find disturbances of somatic function. One of the very common psychogenic disorders is depression. Ebaugh,<sup>4</sup> in his studies at the Colorado General Hospital, found that 20 per cent of the consultations requested of the psychiatric liaison department were occasioned by cases in which depression was the outstanding symptom. Mood swings, and indeed rather marked upsets of mood, are not at all infrequent in everyday life, but depression, as we use the term, indicates a pathological swing of emotions on the down side, that is, a feeling of sadness, frequently coupled with strong feelings of inadequacy, unworthiness and futility, sometimes with an admixture of suspiciousness, or petulance, or irritability. Accompanying this emotional state there are well known physical concomitants, such as insomnia, constipation, headache, and a general slowing down of physical activity. A considerable degree of insight is not uncommon, but the condition by reason of the fact that it lacks spectacular features is very frequently neglected and passed off as a "nervous breakdown," a term which has no place in the psychiatric lexicon. A sinister feature of depression is the possibility of suicide. The patient may feel that he is becoming "insane"; he may feel completely frustrated, and surrender entirely by doing away with himself; or he may seek escape by means of suicide from his imagined persecutors. All too frequently we read in the daily papers the account of some person who has done away with himself, the account often being followed by the significant remark that he has been under treatment for a "nervous breakdown." The unfortunate feature in such cases is that had the patient been protected from himself the chances are very good that he would have recovered from the mental disturbance which led him to take his life. For this reason a particular obligation rests upon the physician who is called upon to deal with a case of depression to bear in mind this very serious possibility. Feelings of self-condemnation and of futility are dangerous signs, and especially if there is a history of previous attempts it is always well to take



seriously threatens to "end it all." Attempts at suicide may occur even while the patient is apparently recovering, and are not at all infrequent following an apparent rapid improvement. Many of these depressions arise in the home and psychologically are linked with situations in the family. For that reason a neutral environment, preferably that of a hospital, is highly desirable. It is unwise to stimulate the patient or to drive him to attempt more than he feels able to do, since if he makes the attempt and fails his despondency is likely to be increased. Travel and change of scene are of rather questionable value, at least without a thorough psychiatric study before they are prescribed. In a depression the appetite is usually impaired, and in deep depressions food is sometimes completely refused. A case of this sort is obviously a hospital case, as forced feeding, particularly by the nasal tube, calls for close supervision. In the early stages the patient, as has been said before, is inclined to have insight, and it is sometimes feasible to persuade him to go voluntarily to a sanitarium as the means of securing for him an environment different from that of the home, and one in which he will be understood. If the patient is to be cared for at home close supervision, although not too obviously close, is important, as is the removal of tempting methods of self-injury, such as poisons, glass utensils, razor blades and other sharp instruments. Attention to the physical functions is called for, and warm tubs at night are particularly helpful in cases of insomnia. The use of sedatives should be limited to barbitol, and only small doses should be used, preferably in capsule form. It is unwise to leave the prescription of this medication to the patient, particularly in view of the fact that fatal doses of barbitol have been taken intentionally by suicidal patients. The use of benzedrine as a stimulant and as a means of lightening the depression is of rather doubtful value. The effects in any event are short-lived and the treatment is entirely symptomatic. It is questionable whether prolonged psychiatric probing is desirable in the acute episode, but at times considerable assistance can be rendered afterward in giving the patient a better understanding of the fundamental difficulty. Ebaugh<sup>4</sup> sums up hospital care as strongly indicated, first, if the patient is actively suicidal; second, when the en-

vironment militates against recovery; third, when the patient is in danger of establishing a stereotyped behavior pattern; and, fourth, when the patient becomes a severe nursing problem, requiring special attention to safeguard health.

#### Still Viewed With Suspicion

Since something has already been said about desirability of care in a mental hospital of this type of patient, a few words would seem to be in order regarding the mental preparation of the patient for such admission. Unfortunately there still exists a distinction in the public mind between the psychiatric and the general hospital, and many patients who would not demur at going to a general hospital are likely to object very strenuously to being sent to a mental institution. This makes the necessity of mental preparation all the more urgent, and such preparation simplifies greatly the task of the physician at the institution. All too often the physician or the family deliberately misleads the patient by telling him that they are taking him, for example, to a hotel, or that they are going for a ride, or by giving some other account which is not only not the whole truth but is a deliberate deception. The patient is thus filled with a considerable amount of resentment against his family and physician after he arrives at the hospital and realizes the truth. If he is taken to the hospital by the police he is very likely to harbor the idea that the hospital is a jail. For that reason the wisdom of the use of police, and certainly in uniform, is in grave doubt. Muncie and Cotton,<sup>6</sup> in a fairly recent study of this problem, ascertained from patients in a mental hospital who were questioned on the subject, that over 50 per cent of those admitted had been given no preparation at all for entry to a mental hospital, and that the same proportion held whether or not the patient had been brought by his family, by the police or by his physician. Not infrequently if the matter is properly presented to the patient he will be willing to seek the aid of a hospital. Physicians in general practice may well be reminded that this form of coöperation has effective beginnings in the adequate formulation with the patient of his situation and that such preparation benefits the patient directly by improving his rapport with the physicians in the hospital. Frankness in dealing with



patients is almost always desirable, and deliberate deception is almost inexcusable.

### Over-Activity

The symptom picture opposite to that of depression is that of excitement, that is, an undue physical over-activity. This is not infrequently associated with elation, that is, elevation of the emotional tone with feelings of expansiveness and of euphoria. In the hypomanic state the patient's conduct shows a change, sometimes sudden but more often rather gradual. Although formerly sober he may become decidedly alcoholic, overtly loose in his conduct, and sometimes very much involved financially on account of his expansive ideas of business prowess. He becomes restless, talkative, over-active, and sleepless. Insight is likely to be poor and he will be resentful of his family's authority. At times moderate use of sedatives, warm baths, rest, and withdrawal from business and other activities may hold the situation in check, but if not the patient will be much better off in an institution. There are other forms of excitement which are much more dramatic, notably the catatonic excitement in dementia precox. In this, instead of there being emotional elation, there is frequently a very marked affect of fear with sudden onset of great physical activity, often with assaultiveness and destructiveness. The so-called "insane strength" sometimes referred to popularly, is largely an artefact—actually the patient is so occupied by his fears and his hallucination that he is not distractible by ordinary means, even by physical injury. The normal desire to avoid physical injury is clouded by his mental state, and he therefore attacks without paying attention to the attempts to restrain him. The case of catatonic excitement is so obviously a case for a mental hospital that further mention is hardly necessary. It may be added that the prognosis in this type is at least fair. The reverse of the catatonic excitement is the stupor, again sometimes sudden in onset and so striking as to be obviously a case to be handled only in an institution. The patient may become entirely mute, refuse food, resist all efforts to move him, become incontinent and have to be fed by the nasal tube. It is sometimes difficult to differentiate the catatonic form of dementia precox from the manic-depressive psychosis which has already been described, just as it is not

always easy to differentiate the other forms of dementia precox, or, as it is frequently termed, schizophrenia.

### The Early Schizophrenic

The early schizophrenic sometimes presents a picture not unlike that of a mild depression or of a psychoneurosis. Where a manic-depressive psychosis may be developed at almost any age, sometimes following a rather definite emotional insult, schizophrenia tends to occur in earlier years of adult life, reaching the peak at about age thirty. There is a tendency to seclusiveness, to daydreaming and fantasy, to emotional dulling and lack of capacity to carry on ordinary activities; to feelings of unreality, a tendency to misinterpret, and the development of vague somatic complaints often referable to the sexual organs; the conduct grows bizarre and not infrequently rather active hallucinations, particularly of hearing, became evident. Often the condition is diagnosed as "laziness" and sometimes "discipline" is advised! The condition is a widespread one, constituting 20 per cent of the first admissions to state hospitals. The tendency to chronicity is rather strikingly illustrated by the figures which were compiled in New York State over a period of fifteen years.<sup>7</sup> It was found that at the end of that period 38 per cent were still in the hospitals, 25 per cent were dead and 37 per cent discharged—only one-third, however, of the discharged group being considered recovered. Some estimate of the economic damage done by this type of disorder is illustrated by the statement, quoted by Cameron,<sup>2</sup> that in Massachusetts the annual maintenance cost alone of patients suffering from dementia precox in state hospitals is \$5,000,000. I venture to emphasize these facts because, although it has long been recognized that early treatment is desirable particularly in these cases, attention has been focussed of late upon this group by the development of the new treatment by means of insulin shock and by metrazol. The work of Sakel and von Meduna, who have been developing this form of therapy, indicates overwhelmingly that the first six months of the disease constitute the most favorable period for treatment, and, indeed, that treatment begun after the first six months is very much less likely to have the desired results. This call for early treatment cannot be empha-

sized too strongly, for the new types of therapy just mentioned, although offering possibilities of improvement or cure which are probably at least 50 per cent greater than those afforded by other methods of treatment,<sup>10</sup> are still far from being a panacea. So much publicity has been given to these new types of therapy that there is no need of detailing them at length at the present time, particularly as the fact must be borne in mind that they are essentially hospital treatments only and not adapted for general practice or even for practice in a specialist's office. Although the risk is small, it is greatly increased if the treatment is administered by persons not thoroughly familiar with it. It is too early as yet to make any positive statement as to the ultimate value of the pharmacologic shock therapy. It deserves and is having a thorough trial, and there is every reason to feel conservatively optimistic. There is, however, evidence that the first claims made were over-enthusiastic. There seems to be little doubt that it is considerably superior to any other method of dealing with these diseases that we now have before us. Our attitude toward schizophrenia is today much less pessimistic than it was even ten or fifteen years ago. With the advance of the treatment of what was once considered almost a hopeless condition, it certainly behooves us not to be guilty of the accusation made against physicians by Francis Bacon in his great work, "Of the Advancement of Learning." Bacon speaks as follows of physicians: "In the inquiry of diseases they do abandon the cure of many, some as in their nature incurable, and others as past the period of cure. Therefore, I will not doubt to note as a deficiency that they inquire not the perfect cures of many diseases or extremities of diseases, but pronouncing them incurable, do enact a law of neglect and exempt ignorance from discredit."<sup>1</sup>

### Neuroses, Minor Mental Disorders

As for the neuroses, the old attitudes are fortunately changing, very decidedly, thanks very largely to the influence of Freud and the light which he and his followers have cast upon the mechanisms involved. It is recognized today that the neuroses are essentially minor mental disorders which are due to emotional conflict and stresses of the environment, most of which are beyond the

control of the patient, and, indeed, exist largely on the subconscious level. The old attitude of impatience which many practitioners used to exhibit at the so-called "chronic neurotic" is much less in evidence today. In the past a good deal of a fetish of the acute has been made, the corollary being that the chronic is not worth attention. As a matter of fact, it may be that acute forms of illness are not quite so common as is generally thought. In any event, the attitude that little or nothing could be done for the neurotic, that he is merely a nuisance, has been responsible to a very large extent for the prevalence of charlatanism, quackery and faith cures—these irregular practitioners have at least given positive assurance, an assurance which was positive as is often the case in inverse ratio to the degree of knowledge, and a strong suggestion of cure. The neurotic in throwing himself into their arms has felt safe, secure for the time being at least, although the amount of damage done by these irregular practitioners and faith healers is almost incalculable. One difficulty in dealing with the neuroses by the general practitioner has been that too much emphasis has been laid on the physical aspect, and the symptoms have been interpreted by the physician rather than giving the patient an opportunity to describe them and to talk about his situation. As a result of the assumption that the patient who consults the physician has an organic condition, many conditions which are fundamentally neurotic but in which many of the prominent symptoms may be referred to various organs have been overlooked. As illustrating the faulty diagnosis which is possible in approaching the patient from the entirely somatic viewpoint, Henry<sup>5</sup> states as a result of his studies at the Presbyterian Hospital, New York, that in the psychoneurotic group referred to the psychiatric clinic of that hospital the average duration has been five years, and that yet a previous correct diagnosis has been made in only about 8 per cent of the cases. It is now generally recognized that some very definite organic symptoms may arise from emotional conflicts, that is, that they may be psychogenic in origin. Some conflicts may be entirely subconscious but the results are none the less real, and it is an error to refer to these disorders as "imaginary." The assurance to the patient that there is "nothing wrong,"



that they are "imaginary" troubles or that he should "forget" them, will not be found helpful at all, but will perhaps drive the patient into the hands of some quack who promises quick relief. The process of getting to the bottom of these difficulties is sometime a slow one and is often a problem for a psychiatrist. Nevertheless, the general practitioner will find it helpful to the patient to give him an opportunity to discuss his symptoms freely and to attempt to explore with him the significance of the symptoms and the situation which underlies them. In some of these cases a formal psychoanalysis is desirable, but it is not always essential by any means, and in many instances much can be done by relatively simple psychotherapeutic interviews. As Dr. C. Macfie Campbell well says: "It is the physician's task to account for all these symptoms, for their origin and their exploitation. The world presented to him is the world as seen through the medium of the patient's personality, and the practitioner's task is to study whatever distorting factors there are in that medium and to consider how best to deal with them."<sup>3</sup>

A good example of a neurosis which is generally recognized and which gives very striking physical symptoms is the so-called "anxiety state." In this condition, which is usually found in tense individuals, there are transient attacks of palpitation, precordial discomfort, perspiration, dyspnea, weakness, giddiness and even fainting. These are accompanied by a fear of danger from within or a feeling of uneasiness and even a fear of death. Noted, too, are easy fatigue, a band-like headache, loss of appetite, feelings of chilliness and clamminess of the hands and feet. The condition is sometimes taken for hyperthyroidism, a condition which itself has rather definite emotional background. The basal metabolism, however, is not increased, the blood pressure is usually normal when the patient is asleep, and the pulse is not especially accelerated except during the height of the attack, although occasional extrasystoles are found. To be sure, it takes time to get at the bottom of the situation causing so much discomfort and inefficiency on the part of the patient, but it is far better to devote that time than to waste effort on glandular extracts, large doses of sedatives or other empirical prescriptions. Occasionally small doses of barbitol may be useful to reduce

the tension, and at times small doses of tincture of belladonna are found useful in the accompanying constipation. Hydrotherapy is helpful for its relaxing effects. The main attention, however, has to be given to psychotherapy. For this not only are time needed and a considerable degree of patience on the physician's part, but in addition a close rapport between the patient and the physician. The difficulty in establishing such a rapport in any system in which the physician is assigned to a patient, or in which the patient has not a free hand in his selection, is obvious. Many other types of neurotic disturbance will easily come to your mind, but the point is that many of them are treatable, that they can be helped, if only the psychiatric nature of the disturbance is recognized and an intelligent approach along psychotherapeutic lines attempted.

It is clear that we have mentioned only a small proportion of the types of psychiatric problems which arise in the course of a general practice. So many situations occurring in such a practice have psychiatric implications that Dr. Edward A. Strecker,<sup>9</sup> one of the outstanding psychiatrists in this country, has given it as his considered opinion that in the first ten years of a physician's general practice it is likely that not far from 75 per cent of his practice will be essentially psychiatric. He includes in this not only the frank neuroses and the neurotic implications of organic disease, but the psychiatric problems arising during convalescence, situations in which one is likely to be confronted either by an undue impatience to recover or else an undue tendency to cling to disabling symptoms. Then, too, one must mention the psychopathological conditions occurring in childhood. We come back, therefore, to the proposition that the successful practitioner is and must be to a very considerable extent engaged daily in the practice of psychiatry. The day of specialism is passing, at least that type of specialism which has been so exclusive as to omit consideration of other factors than those related to the particular organ under discussion. The general practitioner has always stood out as the physician who thought of his patient as a unit, as a total organism. This is likewise the psychiatric concept. The psychiatrist is interested, not in taking the place of the general practitioner, but in reinforcing his efforts and in

coöperating with him in the development of a wider application of the concept of the total organism.

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## THE LIE DETECTOR: ITS HISTORY AND DEVELOPMENT\*

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Regardless of much publicity there are no machines which detect lies, despite the various models of polygraphs on the market sold for the purpose of examination of suspects. Unfortunately, practically all of the authoritative and original scientific data are not available to the public but are confined to the proper scientific vehicles, none of which has been contributed by the personnel of the various State Police Departments or police laboratories now active. In other words, much of the material is being dished out through rewrite men to various magazines and newspaper reporters.

Most of the lay operators naturally are unfamiliar with the basic principles involved and are widely exploiting "Machines." They write chiefly for popular magazines or the newspapers and most of the articles are unscientific and uncritical, concentrating chiefly upon attempts to have "lie detector" records forced into judicial procedure without having any idea of the actual validity of the methods.

In one annual report, secured from a police department, among the various results were four cases of mental disease diagnosed from the polygraphic records.

What results have been achieved then and what is the practical value? These questions certainly cannot be answered by the experiments of laymen alone, even if captains, directors of training schools or laboratories, or graduates in law.

The type of "lie detector" being used most frequently today and giving the best results is some type of polygraph, Lee, Keeler, Darrow, Stoelting, et cetera. This type of apparatus now on the market does not allow the accurate quantitative measuring of blood pressure and most of the operators are incapable of actually measuring the blood pressure or evaluating the cardiovascular circulatory status of the subject. Since there has been no fundamental addition in the test as used by state police of-

ficers, by Keeler and his students from the test procedure as devised by the writer in 1921, this will be discussed for the purpose of orientation and of understanding the slides to be shown. Apparently there is much controversy as to who invented what and many absurd claims made. Actually, no one invented anything. The original contributions consisted in the selection and utilization of apparatus and principles in use for years in physiological, psychological and clinical laboratories. Experiments were conducted and gradual minor modifications of apparatus made. Of the chaotic popular literature and many claims by pseudo-experts and of all the physio-chemical possibilities of approach, we are interested chiefly now in the actual investigations reported in the scientific literature dealing with physio-psychological research, not with the emotions alone but with actual application of deception tests and not with arm-chair speculation. Since the publicity attendant upon spectacular cases, about every type of instrument and measurement of psycho-physical reactions has been suggested by someone in some newspaper write-up, and possibly one or two subjects tested. What are the trends and the reported results by qualified investigators? The entire literature has been surveyed in two books: "Lying and Its Detection" by Larson with Haney and Keeler, University of Chicago Press, 1932; and "The Lie Detector Test"

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by Wm. Marston, Richard R. Smith, New York, 1938, now released. The former is technical in nature and the latter admittedly written in popular style for the public.

We are especially concerned with the writings or early experiments of Lombroso, Jung, Munsterberg, Benussi, Marston, Larson, and now recently and indirectly with the works of Luria, H. E. Burtt, Edwards, Miles, Keeler, Darrow, Renshaw, and Higley as far as refinement of technic and improvement of apparatus is concerned. The genesis of the present method and apparatus may be listed for convenience as follows:

1. *The practical application of the word-association reaction time method* with especial application to guilt or innocence and complex situations is focused about the pioneer work of Jung and Munsterberg. Its limitations were summarized in a rather humorous survey of the literature in this field by Wigmore in the *Illinois Law Review*, in 1909. This method as far as originally applied has fallen chiefly by the wayside except for the recent work of Crossland of Oregon. The literature in this field is voluminous as far as psychological studies are concerned but only of secondary interest in medico-legal work.

2. *Lombroso*, contrary to rather recent popular accounts, actually took pulse tracings which showed relative pressure or circulatory changes of suspects being tested as to innocence or guilt as early as 1881.

3. *Benussi*, in 1914, published experiments in which respiratory, inspiratory-expiratory ratio changes were found to be diagnostic of lying. These were later repeated by many others with varying results, including H. E. Burtt, Marston, Landis.

4. *Marston* is probably the best trained layman in the field who has applied clinical methods to the detection of deception. He secured his M.A. in Psychology at Harvard under Munsterberg, a pioneer in legal psychology in this country. He also has a degree in law, and a Ph.D. in Psychological Physiology from Harvard Medical School. Although he published original experiments in psychological and legal journals in connection with association and reaction time his chief original contributions to the criminological field were in connection with the so-termed "Systolic Blood Pressure Marston

Deception Test." His early experiments convinced him that deception was accompanied by an increase in systolic pressure. He took readings at definite intervals. This was his original contribution as published in psychological and criminological journals prior to 1921. More recently he has included the technic essentially as used by the writer and polygraph operators.

5. *Larson's experiments—the Berkeley "lie detector."*—Marston, in his very recent book, gave Larson the rather dubious credit for the police adoption of the deception test. "Dubious" because oversold by the enthusiastic backing of Vollmer and spectacular result of Larson's three years of routine police experiments, against his reiterated admonition non-medical men, relatively untrained psychologists, police officers, and others are buying machines, grinding out records without the faintest concept of what it is all about. After disregarding his objections and ploughing headlong into difficulties, they then run to the speaker expecting that he can miraculously extricate them from their difficulties. Still refusing to heed his warnings, they attempt to force tests into judicial procedure and rationalize their lack of experience and necessary training by empirically excluding formal training in the basic medical and clinical sciences as being unnecessary.

Feeling that Marston's discontinuous method, although reported very satisfactory, was inadequate, the writer devised a test method for routine testing which has remained essentially unchanged whenever so-called polygraphs are used, the various changes being mechanical in character. The principles made use of were described in psychological and criminological journals beginning in 1921. The factors made use of consisted of:

1. Continuous record of respiration—much simpler than Benussi's.
2. Reaction time and association words included in questions or alone in studies of complexes.
3. Continuous modified plethysmographic and blood pressure curve by the Erlanger modified method.
4. Quantitative measurement of systolic and diastolic blood pressure as indicated by Marston in modified form.
5. Time curve secured by a chronoscope.

Of the above factors incorporated in the test, the only one up to this time indicated by Marston in the scientific literature was number four, but it was the impetus of his work that suggested practical possibilities to the writer. The unique feature number three was adopted in modified form from Erlanger's method of determination of blood pressure. This was selected in preference to the use of galvanometers of all types for several reasons. Previous to the application of this technic by the writer, there were no actual cases showing these graphic records in deception tests published as far as can be ascertained. Likewise, there were no records of tests shown combining the other factors. The records were called by the writer cardio-pneumo-psychograms. They were simultaneously used in the study of all complexes and as modified psycho-analytic procedure.

The procedure was simple and as follows:

1. Permission was secured in writing.
2. A record of breathing and Erlanger sphygmomanometer were secured without any questions.
3. Indifferent questions were given, to be answered truthfully and by "yes" or "no." These were so selected that an incorrect answer was obvious.
4. Crucial association words or questions were then given. Finally it was decided to use questions and for important reasons not to alternate indifferent with crucial questions.
5. The subject is then requested to reverse the answers to all of the questions.
6. Systolic and diastolic pressure are taken by a separate sphygmomanometer, auscultatory method.

Chief Vollmer coöperated and was always enthusiastic. At first, old physiological apparatus was used in the University of California. Later, a more compact apparatus was assembled for the writer by Earl Bryant. In 1923, the apparatus was simplified to an inked polygraph by Bryant.

The advantages of the continuous graphic method of registration are manifold, being objective, permanent records which can be filed as a part of the investigation. Since this work with the ink form of polygraph, there have been many types of polygraphs and electrical machines advertised as "lie detectors."

While in California, a high school student, Leonarde Keeler, observed some of

the Berkeley experiments and assisted in photographing a few records and on one trip when the writer gathered records of various types of patients at an institution for the feeble-minded, Keeler began actual testing of cases for Vollmer, in 1924, in Los Angeles. Interested in manufacturing a polygraph after working with Professor Edwards and Miles in California, he finally patented a polygraph and released it on the market about 1927. A very active operator in the field after securing his A.B., he has devoted his life to this type of work. He has placed polygraphs and trained many investigators. Some of them are in operation in the State Police Departments of Pennsylvania, Indiana, Michigan, Rhode Island. The operators, Funk, Kookan, and Mulbar, in the first three states are especially enthusiastic. Michigan began routinely using the polygraph about 1934. These departments and Wichita report a high degree of success, confirming the previous findings of the writer in Berkeley and Illinois. Keeler has established an extensive commercial service for the banks and commercial houses of Illinois.

The first marked change in the technic was made by Chester Darrow in his photopolygraph. Here he incorporated galvanometric tracings and the tremographs of Luria. Although Darrow has not worked with the problem of deception in criminology, he pointed out experimentally that the respiratory and blood pressure curves showed more variation with emotional stimuli than the psychogalvanometric tracings. He is especially interested in the relation between the two types of registration, blood pressure and galvanometer, in the study and attempted differentiation of clinical types. He calls this ratio an "autonomogram." Recently, he has reported a method for the quantitative determination of the various types of blood pressure by a continuous method and plans to incorporate this with his photopolygraph. This has not been possible with the Keeler polygraph. About the same time, Higley and Renshaw of the Department of Psychology at Columbus devised a modification of the Erlanger method. Having used the chief forms of the present polygraphs now in use, including the Keeler, for some four years, the writer prefers the Lee type for ordinary criminological work and the Darrow where the operators are sufficiently trained.



Luria's method of the study of emotional changes by the study of neuro-muscular change of tone is very simple and useful. This has been applied chiefly to personality studies and not so much to the determination of innocence or guilt *per se*. This method should be used with the polygraph.

Some thirty-two slides of the historical development and illustrative cases were shown. This material included summary tables of psychiatric, police, court, and prison cases. The following points in the summary were discussed with the appropriate slides.

### Summary

1. The present status of deception tests or the use of so-called "lie detectors" is one of extreme chaos.

2. Much of the difficulty is due to the fact that laymen are using the most complicated clinical instruments of precision and are often making impossible clinical diagnoses.

3. Too much attention is being focused on the exploitations of machines for profit with no understanding of the basic scientific or ethical principles involved.

4. Attempts are inadvisedly being made by enthusiastic experts to force this technic into court usage very prematurely.

5. Conducted by a suitably trained staff which must include a clinician, deception tests may be invaluable in service, first in the primary investigation as an adjunct only after securing their permission to the present methods of cross examination and, secondly, in Court clinics and private laboratories as a part of psychiatric technic in modifying psychoanalytic procedure.

6. Even with the present unscientific application in which the technic is used by many as a psychological third degree, there has been a marked increase in the clearing up of cases.

7. There is a tendency on the part of academic investigators to over-emphasize the results of demonstrations or the use of deception tests in artificial situations. Lying about indifferent situations especially in front of audiences of students and reporters has no significance whatsoever as far as the results of such experiments are concerned and the evaluation of the occurrences working on the firing line in actual cases.

8. No apparatus diagnoses deception but

merely painful complexes which must be differentiated as in any differential medical diagnosis. There is no disturbance graphic or in quantitative physiologic terms specific for deception.

9. All deception tests should be a part of an analysis of the crime setting integrated with each individual personality analysis. Neither medical nor criminological training alone is requisite but a combined staff consisting of the investigators, the examiner ideally with legal psychological training, and a psychologist and licensed physician or a forensic psychiatrist. These last three named should be present throughout every examination.

10. Because of the errors of interpretation, and these have been found to be large, a deception test alone should never be used as court evidence. If incorporated as a part of a psychiatric examination, the test records alone should never be used as indicative of guilt or innocence.

11. An experiment is now under way in which the validity of the test method as to innocence or guilt is concerned. This includes a correlation of the subjective cues of the investigators, the interpretation of the records and the physiologic responses when lying about a crime on the firing line or in police situations.

12. During some seventeen years of personal experience, the writer has never had a suspect "booked" or released from custody relying upon a deception test alone. In one criminal case, Federal, the writer was upheld by the court in refusing to comment upon the findings of a deception test. He testified with Keeler before a court in Wisconsin where it was felt that the suspects were innocent, but refused to participate in the attempt to introduce "lie detector" findings in the Kirkland case of Indiana. He refused to test defendants in a domestic relations case for a Chicago court. He was cross examined in a civil suit case as to the innocence or guilt of Kuhn when examined as to extortion.

13. The objection that the fear of the innocent, anger of the innocent, experiences in crime, nervousness and mental disease may vitiate a deception test need not interfere with the securing of positive results. These factors naturally can interfere and the extent of this is dependent upon the clinical experience of the examiners. Good or superior intelligence has not been found

to interfere. Mental deficiency may or may not, depending upon the individual setting.

14. When many suspects are tested, it is often difficult to differentiate the specific guilt reaction. In one case in which sixty-two suspects were examined by the writer and a trained clinical criminologist, using the Keeler polygraph, there were many disturbances. The type of polygraph makes but little difference. A group of nine, most

of whom were clinical psychologists, including four whom the writer would qualify as experts in this field, showed wide divergence. The percentage of records selected as being guilty varied from 8 to 52 per cent. The most accurate interpretation was by a clinician who had never seen a deception test or records from such. The highest percentage of error was among those most familiar with the procedure.

## THE MEDICO-LEGAL ASPECTS OF THE POLYGRAPH OR "LIE DETECTOR"\*

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The "lie detector" brings up in all of its essence the problem of expert testimony by the medical man before the criminal courts. It requires a highly specialized technic for its operation and yet the machine itself is very simple. I do not think that at the present time there is any likelihood of using a simple piece of apparatus as factual testimony per se but it can be used largely as supportive testimony in the hands of the expert.

I have been very much interested in this problem of using the polygraph, the photopolygraph, or the reflexohmeter in the Court, because of the fact, for one reason, that, as far as I am able to ascertain, I am the only one in Michigan who has testified about the use of this machine under examination and cross-examination in a criminal case. This case was a commission hearing under the 1937 Act No. 196 which provides for the incarceration of a sex deviate in a hospital rather than in a penal institution.

In this case our examination showed probabilities but was by no means conclusive. The individual had been arrested three times on sexual charges but denied his guilt on all occasions. The testimony against him was largely that of very young boys, although in one instance, at the time of his last arrest, the police found him in the company of two small boys in a field even though they were not committing an anti-social act. Had we been willing to go on his record alone, the fact that he had two previous convictions might have justified us in assuming right off that he was a sex deviate. In examining him psychiatrically we found the usual feelings of inferiority on a sexual basis, the idea that he was impotent, and a very deep mother attachment

which, in our experience, are pathognomonic in sexual offenders of certain kinds. It was our opinion, therefore, from the mental picture which he presented, that in all likelihood he was a marked sex deviate and came under that law. However, this was an opinion based purely upon our examination. There is no definite scientific evidence in the literature, by way of reported fact, that a mother attachment or feelings of inferiority do give rise to pedophilic tendencies, although in our extensive experience in the Clinic we are inclined to believe in a very definite causal relationship. The man willingly went on the lie detector, as so often patients do who think that they can fool the examiner, and gave a typical lying record.

His lawyer wished to put up as good front as possible and demanded a jury hearing on this man's sex tendencies; he cross-examined the three physicians in the case extensively, keeping each of us away from the other two until our testimony was completed, and naturally, since the facts which we had elicited were known to all of us, our testimony hung very closely together, although we may have emphasized different points. When I was called on the stand I

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mentioned the fact that this man had been run on the polygraph as conclusive evidence, since my mind was practically made up on a basis of the psychiatric findings and I felt that his guilty polygraph record with particular emphasis on sexual interests was important.

### Importance of Examining Apparatus

I think here is probably where the greatest value of the polygraph rests today. It can be used as a piece of examining apparatus the same way that in our physical examination we use the ophthalmoscope and stethoscope. From it the Clinic has already been able to confirm its previous idea about a case derived from history and psychiatric findings, even though a patient would not admit his guilt. In many cases this is very important because if the man can be gotten to admit his guilt, and he can express himself about some of the mechanisms involved in his case, treatment can be instituted.

However, as I learned from my experience in this case, there are a number of pitfalls into which the physician can trip. It is too often forgotten by physicians that expert testimony is opinion testimony, that there is no reason at all for giving the facts behind the opinion except that no jury, and probably no judge, is likely to weigh the unsupported opinion of an expert on one side as being very significant against the testimony of the expert on the other side who produces his records, gives the reasons for his conclusions, with such objective or laboratory findings that he might have which he can present simply enough for the jury or the judge to understand. The value of the polygraph, therefore, in court would depend upon the ability of the physician himself and the use to which he has put the machine.

The ability of the physician is predicated upon his training, his experience, his thoroughness, and the background upon which he has built his knowledge of the piece of apparatus or the technics which he has used. The psychiatrist who testifies on the stand that he asked a lot of questions but cannot repeat the questions, or point out in what direction his questions were leading, is indeed handicapped when his confrere, who is either on the other side or is acting as court psychiatrist, can bring down a transcribed question and answer record which was taken through a dictaphone and which

describes in great detail the delusions and bizarre ideas of the defendant.

When using the polygraph, therefore, it is necessary for the physician to qualify himself as being an expert in its use. Now, this does not mean that he must be the technician who puts ink in the needles and turns the current on and off for the paper to pass over the traction roller, but it does mean that he must be able to observe the way that the record is being taken, to know that all the scientific precautions are being taken such as concealment of the instrument from the eyes of the patient, blocking out of outside auditory stimuli which may be of great importance, particularly on the photopolygraph which records so extremely sensitively the patient's reaction to extraneous sounds and sights, and such knowledge can only come from considerable experience, not only with this apparatus but with all physiological apparatus. As a matter of fact, in our Clinic, insofar as we can do it, we insist upon exact scientific surroundings. We cannot, of course, obtain a soundproof room but we do keep our door closed and we give the patient sufficient time to become accustomed to his surroundings. We use other precautions, but these will serve to indicate some of the very elementary considerations which may confront the expert if he is not careful and not properly trained, and which he may disregard to his sorrow.

### Qualification of the Expert

The second place where the expert must have special knowledge in order to be qualified to testify, or even to use this equipment as a technic for verifying other findings, is to have a thorough medical and psychological as well as psychiatric background. To the layman, and by the layman I include the non-medically trained police officer, fluctuations of the blood pressure recorder in the polygraph, and more particularly in the photopolygraph in the form of Traube-Hering waves due, as you know, to respiration, may very often give the idea of great tension or lying by the patient. These features of the record the expert physiologist can immediately rule out with a glance.

I do feel that the physician should always be in the room while the record is taken and the long distance diagnosis which we hear about when the equipment is used by the police smacks somewhat of the Abrams electronic devices about which we heard so

much a decade or so ago, for without seeing whether the patient moved at the time that the so-called lie was recorded, observing a change in attitude toward the machine, or studying his attitude toward the questions, the record is worth nothing. To the trained psychiatrist who has had a good deal of experience with a piece of apparatus of this sort, it is very often possible to diagnose an impending mental breakdown not so much from the record but from the conduct of the individual while the record is being made.

Occasional cases have been reported to us where policemen and others have attempted to diagnose schizophrenia or arteriosclerosis from these records. There is nothing in the literature as yet to indicate that such a diagnosis can be made. Darrow,<sup>1</sup> in Chicago, has showed certain tendencies in the records of psychotics. He has not ruled out their presence in normal individuals.

A physician, then, is not likely to make a psychiatric diagnosis on a basis of photographic or paper record when he can see the man right in front of him, but if he does see a record that is typical of findings such as those that Darrow considers suggestive, and he has all of the clinical symptoms in addition, he is in a good position to express an opinion to the jury and the machine offers some supportive information. When qualifying a doctor to testify on the lie detector, I do not believe that we are ready as yet to set up definite standards. It must certainly be true that those of us who have used this machine more frequently than others, who have a background in medicine as well as in physiology, are more likely to be conservative and are more likely to have fallen into the various traps which open for the unwary at one time or another before being subjected to cross-examination. Such an expert can admit frankly without damage whether he knows a certain fact or whether he does not, and he can give reasons for his belief by citing previous cases which have been verified either by confession or by some clinical material obtained from other sources and correlated with the polygraphic findings.

#### Lie Detecting Device as a Check

What are the possibilities for using this type of apparatus in a medico-legal situation? This certainly is a scientific device

which has been used for various purposes for a number of years. Even its "lie detecting" properties have been thoroughly analyzed by Dr. Larson.<sup>2</sup> In the hands of Verne Lyon, of the Juvenile Court, in Chicago, it has been most useful as an ancillary to the usual examination procedures. Lyon's use of this equipment is the same as ours in the Clinic, merely to bear out the findings of other types of examination. It is conceivable, and, as a matter of fact, within the realm of our own experience, for the findings on this apparatus to prove to us that results of other kinds of examinations have been erroneous and to point out the need to check back.

This was particularly true in a recent case which we examined in the Clinic partly before sentence, partly after sentence. The patient was unwilling to go on the machine but for the purposes of research we were very anxious to make a thorough study of him. Through the coöperation of his lawyer—and we must say that the lawyers of Detroit have been almost one hundred per cent coöperative with us when we want to use this equipment—we were able to get him to submit to an examination. The record on the photopolygraph which we used in that case showed a great deal of emotional apathy. It was the opinion of our examiners that this man might psychiatrically be a schizophrenic, but during the trial the question of schizophrenia was never raised although the question of the man's insanity at the time of committing the crime was. At that time, there was the usual difference of opinion among the psychiatrists. One side maintained in answering a hypothetical question that the man was mentally sick and the other side maintained that the man definitely was not legally insane at the time that he committed the crime.

After seeing the photopolygraph record, and after observing him psychiatrically as well as making a number of other tests, we were of the opinion that legally, perhaps, this man would not qualify as being insane. Yet he was very definitely a schizophrenic as far as his internal mental mechanisms were concerned. This case points out a use of the machine in diagnosing borderline conditions.

We make a diagnosis of myocardial insufficiency or of valvular disease of one sort or another through our usual clinical facilities, and the electrocardiograph permits



us to be very much more definite, to predicate our treatment directly upon the symptoms shown in a fixed record. In this way, in dealing with mental traits, both the polygraph and the photopolygraph are extremely useful.

It is necessary to distinguish between the extra-mechanical use of this equipment and use dependent upon its mechanical precision. The extra-mechanical use consists in convincing the suspect that he will be caught telling a lie, or, if he refuses to submit to the tests, that there will be a strong suspicion that he is lying. To this use I do not think any physician can subscribe. First of all, it means that we must convince our patient that the machine is infallible and I am sure that we will all admit that it is not infallible and that perhaps by itself it is not even directly diagnostic.

The second extra-mechanical use depends on the type of questions which are asked. In the case which I have just recapitulated briefly the man insisted upon having the questions read over to him, demanded that they be so reconstructed that he could answer them "yes" or "no" without committing himself as to whether he had any vicious ideas at the time of committing the crime, and in that way he removed a great deal of the complexes which would exist in his mind when the question was asked, thus showing a diminution of responses on the record.

The mechanical use of this equipment differs with the type of machine that we use. Electrical equipment which depends on the changes in skin resistance used in the reflexohmeter and the psychogalvanic device in the photopolygraph registers changes in resistance due to fear or tension in which the hands perspire imperceptibly and change a record which is similar to that of the electrocardiograph.

Another means of testing complexes, the existence of which may be even unknown to the subject, is the response time test such as those made by Jung and Kent and Rosanoff where a word is given to the subject and he is timed to see how long it takes him to associate another word with it and whether he gives an unusual response. This we can also test on the photopolygraph. There is a third type of equipment on this machine which permits diagnosing conflicts which has to do with the individual attempting to move his hand and respond to the question

at the same time, so that strong emotion will give a very marked manual deviation in the record which we take from the fingertip.

All of these physiological changes are very important if we are going to devise treatment means in a clinic after conviction to show us into what part of the mind we must dig in order to bring the unhealthy thoughts into the open for therapeutic purposes.

#### Contraindications to Use of Lie Detector

I might mention in brief some of the pitfalls which exist in handling this machine. One of them is very frankly the danger of putting an individual on such a machine if he has a weak heart or if there is a tendency toward an epileptic attack. It was only recently that a defendant was brought into our court and passed into a syncope merely because of the court situation and next day died. This was due to a coronary occlusion of some sort apparently but we can readily see that if we had put him on the machine he would have been even more likely to have passed away.

One last word of warning: In order, then, that a man may testify or even use the machine with fairness in a court situation, it is my firm belief that he must have experience with the machine and experience with the criminal. He must know when the man is merely reacting to criminal training when he refuses to go on the machine and is not necessarily guilty. He must be enough of a physiologist, as I indicated before, to be able to interpret the record. He must be enough of a psychiatrist to interpret the type of response at the same time that the record is being made.

This is an even more important complex situation with the photopolygraph which records all sorts of bodily changes, than with the "lie detector" of the older type. These qualifications do, I think, eliminate all but licensed physicians as operators, and perhaps even a physician would do well to think twice about expressing himself in regard to a record or the machine itself.

I should like very much to thank the medical profession who have coöperated so well in the past in the use of this equipment and all of our clinical problems, and also the legal profession, many members of which have shown a great understanding in the work of the clinic, not only in the use

of this equipment but also the equipment for testing drivers in our Traffic Division. Without their help we cannot expect to advance science so that courts will be able to cure criminals rather than merely sentence them. If we do not attempt to cure them they will be returned to society in as dan-

gerous shape as they were at the time that they committed their crimes.

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## DESENSITIZATION TREATMENT IN SKIN DISEASES\*

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If a guinea pig is made sensitive to egg, its uterine muscle removed and suspended in a water bath and if egg is then added to the bath, a marked contraction of the muscle takes place, indicating that the uterine tissue has been sensitized. After this reaction, the muscle will not contract for a short time if egg is again added to the bath. It has temporarily acquired a state of protection against the egg, a state of non-reactibility, called anti-anaphylaxis. This phenomenon can readily be observed with other organs in addition to the smooth muscle, such as the brain substance, the cornea of the eye and the skin, where the reaction is not that of a muscular contraction but an urticarial wheal. In fact, the whole organism of a guinea pig which has recovered from anaphylaxis following a sublethal dose of antigen has acquired such a protection that it will subsequently tolerate a much stronger dose than one which ordinarily would be fatal. Upon this fundamental experiment is based the so-called desensitization treatment, sometimes also designated hypo-sensitization treatment, since in man complete desensitization is said not to be possible.

If applied to the treatment of allergic diseases, particularly of allergic skin diseases, the problem of course becomes much more complicated than in an experimental animal. The reasons for the difficulties lie in the following facts: 1. In all allergic diseases there is usually more than one antigen involved and it is often extremely difficult to determine which are the primary sensitizing antigens and which are of minor significance. 2. The skin lesion is usually more or less continuously affected by the invading antigen, not only through surface contact but also through absorption through the respiratory or gastro-intestinal tract. Thus the quantity of antigen continuously reaching the skin tissue may interfere with the formation of a temporary state of protection.

The subject of desensitization treatment may best be illustrated by referring to a phenomenon which is occasionally encountered. An injection of horse serum, of typhoid vaccine, of milk, an acute infectious disease, an injection of iron or of any other foreign material may in one case result in considerable improvement of the existing allergic dermatosis, in the other case in a marked aggravation, sometimes even in death. We can readily understand this peculiarity if we consider the instance of an injection of pollen extract in a hay-fever patient with pollen dermatitis. This may serve the purpose of an illustration best because, as a rule, we are dealing with a known dose, with a rather well known degree of sensitivity in the patient and usually with only one primary dominating antigen, the pollen. Let us assume the patient's sensitivity is such that 30 units is the upper limit at which a dermal wheal can be produced without a generalized reaction. If this patient were given 40 units he would suffer an aggravation of his dermatosis and generalized symptoms, such as sneezing, asthma, hives. If he were given 3,000 units, very severe symptoms would be encountered, possibly even a fatality. On the other hand should he be given an injection just below his threshold of 30 units, the skin lesion would in all likelihood improve and through further injections his system would

\*Read at the meeting of the Michigan State Medical Society, Section of Dermatology, as part of the symposium on allergic skin diseases, 1936.



acquire such a protection that the 3,000 units would no more harm him. In other words, with different doses of the same antigen we may cause considerable improvement or great damage. The production of a generalized reaction should, therefore, always be taken as an indication that smaller doses with the same material will be therapeutically successful.

### Indications

Besides prophylactic treatment there are two indications for desensitization: Firstly, to build up a more or less permanent resistance against those antigens which cannot be fully eliminated from our surroundings. I am referring to pollen, fungi, house dust, cotton or, in the case of infants, to the most important foods, namely, milk and eggs.

The second indication is the relief of an acute allergic skin lesion regardless of whether or not the antigen can be eliminated. Whether we are dealing with an acutely exacerbated contact dermatitis of the poison ivy type, an atopic eczema, or a fungus infection, one to two injections of the main causative antigenic agents is likely to bring considerable, if not full, relief very shortly, provided that the right antigen is administered at the proper dosage. In this manner the skin lesions behave exactly like the nasal lesions of a hay-fever case which can easily be controlled by a properly dosed injection of pollen extract. This treatment should be carried out very cautiously, since a slight overdose may aggravate the condition considerably; on the other hand, a dose below the amount required is ineffective.

### Mode of Treatment

The most successful mode of desensitization is by hypodermic injection, since it permits the control of the amount of antigen which enters the system and which reaches the allergic tissue. This control is not possible if desensitization is attempted by mouth or by other routes. In oral desensitization with foods for instance, some of the ingested antigen is often eliminated with the feces and thus not fully absorbed. A subsequent amount and based on the previous dose administered ingested may, therefore, act as an overdose. Furthermore, new irritations in the gastro-intestinal tract may be set up and develop into additional allergic foci. I found this to be particularly strik-

ing in cases of food sensitivity in which the offending foods had been given by mouth in gradually increasing doses. By producing repeatedly local wheals on the skin with the most strongly reacting foods, considerably better results are obtained.

Whether injections are given subcutaneously or intradermally seems to be of little moment. In co-seasonal pollen treatment in approximately fifty hay-fever cases, Freshman and I<sup>1</sup> obtained the same percentage of relief in two groups of patients in whom the injections were made subcutaneously and intradermally, respectively. A definite advantage with intradermal injections is the fact that local reactions are more superficial and that thus the dose for subsequent treatments can be gauged more easily. Furthermore, in intradermal injections it is easier to avoid accidental puncture of venules, which is the source of the most common and most severe generalized reactions (Waldbott and Ascher<sup>2</sup>).

Topical desensitization has been attempted in case of contact dermatitis, particularly in poison ivy. If local baths of the affected skin areas with increasing concentration of a solution of the offending antigen are given, the doses reaching the skin lesion can be properly controlled. This method may prove to be of special value in contact dermatitis due to dyes and other chemicals in which no hypodermic desensitization is possible.

Another type of topical desensitization is the application of cold water, ice, and heat in gradually increasing doses as recommended by Duke. This is a very definite aid in the management of all types of allergic diseases, particularly of urticaria and contact dermatitis, in which heat and cold sensitization plays an important part.

### Types of Antigens

In desensitization by hypodermic injections proper, three groups of antigens can be distinguished which act differently in their biologic response. Strangely enough, the effect of injections with these three types of antigens parallels remarkably well with the common classification of allergic skin diseases. They are the atopic antigens, the contactants of the poison ivy type, and antigens of micro-organisms.

The first group of antigens are the ones most widely used in all allergic diseases. Their chief exponents are the pollens. This

group comprises practically any antigen of the inhalant or ingestant type. The response of the lesions takes place within  $\frac{1}{2}$  to 1 hour after the injection. Excessive doses or accidental puncture of venules lead to reactions which closely resemble the picture of acute anaphylactic shock in animals, namely, sneezing, generalized hives, wheezing, etc.

The second group are the contactants, particularly the plant oils. As a rule one or two injections are necessary and a beneficial response of the lesions may take place immediately. An excessive dose may bring on an immediate reaction which is characterized not by urticaria or by other allergic symptoms as is the case with pollen or serum injections, but by an aggravation of the epidermal lesions, usually a bullous or vesiculo-papular eruption. These antigens lend themselves particularly well to prophylactic purposes. Those most commonly used in my practice are poison ivy, the oil extracts of pollen or leaves of the most common hay-fever plants and of chrysanthemum and primroses; furthermore, wool, silk and cotton oils. According to Blumenthal these materials lend themselves also to oral desensitization.

The third group are the antigens of the bacterial type; their main exponent is tuberculin. Bacterial vaccines and fungus extracts appear to behave in a similar manner. It is true, there may be an immediate local or general response of the type seen after pollen injection. But, as a rule the local or general reactions usually reach their maximum effect after a 12 to 15 hour interval. While an overdose may also result in a temporary aggravation of the lesions, the generalized reaction usually assumes the picture of a more or less marked infectious disease characterized by fever, glandular swelling and a localized inflammatory irritation as evidenced by swelling and pain at the site of injection (Waldcott<sup>3</sup>). Just as the course of an infectious disease may produce a temporary immunity, a generalized reaction with bacterial antigen usually results in considerable relief. The most important one of this group, in the use of skin diseases, is the trichophyton and oïdomycin extract, which I have found to be very helpful. If this treatment is unsuccessful, it suggests that the fungus lesion may be complicated by secondary sensitization or it may have

arisen as a superimposed infection upon a previous allergic or contact dermatitis.

### Choice of Antigen

For immediate relief I found it useful to select any antigen to which a marked skin reaction has been obtained. Even after a single application of skin tests we frequently notice marked improvement without additional therapy if some of the skin reactions had been strongly positive. It is the production of a local wheal by hypodermic injection which is to be desired, no matter what antigen is used. For preventive and curative purposes, however, only those antigens should be selected which are of primary clinical significance. For their evaluation both the intradermal and patch tests are of less importance than the history, the clinical observation, and thorough knowledge of the patient's surroundings.

In selecting the antigens one should remember that certain dyes, drugs and other chemicals are of necessity dangerous and cannot be injected into the system. While in allergic eczema of infancy and early childhood the food factor is more prevalent than the other antigens, it is well to bear in mind that in adult eczemas the relationship of foods to epidermals and pollen parallels closely that in asthma and other allergics. The significance of pollen as a common primary cause of chronic eczema as well as of contact dermatitis can be explained if one considers two features paramount in the production of allergic phenomena, namely, periodicity and continuity of contact. Periodically for several months of the year there is a prolonged absorption of pollen through the respiratory mucous membranes throughout days and nights, a feature which is in contrast with the mode of absorption with other antigens, particularly of food.

### Technic of Treatment

It is impossible to give a set schedule for treatment in any one case. Each dose should be individualized on the basis of the following considerations: (1) The extent and acuteness of the local lesion; (2) the degree of individual sensitivity to the respective antigens; (3) the local and general response to previous injections; (4) the time interval between injections.

For immediate relief it is best to give very small doses at more frequent intervals



with very little if any increase (Waldbott and Ascher<sup>4</sup>). If more permanent protection is desired larger doses are essential. In general it is desirable to raise a wheal at the site of injection with the smallest possible dose of antigen. The extent of the local swelling, the improvement or the aggravation of the lesion should determine the subsequent dose and interval between injections. It is dangerous to continue to increase the doses if too marked a local reaction persists from a previous injection. On the other hand, if there is little or no swelling the time interval should be lessened, the doses more rapidly increased, or the case should be re-investigated, since the antigen given may not be of primary importance. Elimination of as many sensitizing antigens as possible should be carried out at the time of treatment. If contact with certain antigens continues either through inhalation, ingestion infection or through local contact the doses should be considerably reduced, as the combination of both injections and natural contact may act as an overdose.

#### Avoidance of Reactions

Reactions are either due to an overdose or due to accidental puncture of venules. Reactions due to an overdose are always preceded by the rapid appearance of a wheal at the site of injection, from where the general symptoms are likely to spread. They are harmless even with excessive overdose, since the application of a tourniquet and small injections of epinephrin will result in prompt relief.

However, accidental intravenous injections or back-seepage of antigen into an accidentally punctured blood vessel are fraught with great danger. While there is no definite means for their prevention, the following precautions can be recommended: careful selection of the site of injection in order to avoid veins; repeated withdrawals of the plunger before injections in order to look for evidence of blood, watching the site of injection for bleeding and giving

epinephrin in 1 to 2 c.c. doses immediately upon the slightest evidence of intravenous reaction, namely, within a few seconds after the treatment.

#### Failure of Treatment

The most common reasons for failure of desensitization treatment are either insufficient doses, overdoses or too intensive treatment, improper choice of the causative antigen and simultaneous presence of other allergenic factors. In a simple ringworm infection, for instance, there is often also present a probably acquired allergy to foods, epidermals and others. Frequently, the reverse is true, namely, that eczema and contact dermatitis will supersede a skin infection brought on by fungi or by bacteria. Thus, I have repeatedly encountered failures in poison ivy dermatitis with treatment of the poison ivy extract until oïdomycin was added to the injections. In a recent case of contact dermatitis due to phenylendiamine a staphylococcus infection had supervened which promptly cleared up after one dose of a specific vaccine was administered.

In some of the more complex atopic skin lesions in which several intradermal and patch tests gave strongly positive reactions the lesions could not be controlled until four to five different antigens had been administered.

#### Summary

In summary, may I state that desensitization therapy in allergic diseases should be highly individualized. It is not fully devoid of danger. The results depend on thoroughness, intuition and skill of the physician and coöperation of the patient.

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## MANAGEMENT OF CIRCULATORY FAILURE\*

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Within the past few years two demonstrations have been of prime importance in the elucidation of the mechanism of circulatory failure. These two are, first, the demonstration of the chemical mechanism of muscle contraction, and second the interdependence of blood volume changes and the shock syndrome. These are two epoch-making discoveries to which no one man's name can be attached.

A discussion of the management of circulatory failure could not have been intelligently carried on without the knowledge gained from the two demonstrations.

This is not to be a discussion of heart failure in the usual sense of the phrase, although in any discussion of the circulation the heart cannot be ignored.

I call to your minds that the left ventricular heart muscle is made up of innumerable scrolls of fibres in turn made up of syncytium of myriads of heart muscle cells. There are no end plates of nerve fibres and there is specialized nerve-muscle tissue which ramifies all over the heart muscle. Up to within recent years, pathologists have been trying to tell us the cause of death in heart failure by examining the cells with the microscope. People died of heart failure yet no specific changes were discoverable in the hearts.

The heart muscle must have  $O_2$ , glucose and insulin in order to perform its work. The mechanism of contraction is complicated. Suffice it to say for our purpose that a substance called phosphocreatine is an important component of the muscle and in the presence of  $O_2$ , glucose and insulin breaks down. The heat liberated produces lactic acid from glucose and resynthesizes the phosphocreatine. The lactic acid is carried to the liver, where it is synthesized into glycogen, which is the source of glucose. So the circle goes on in health. We have learned that the heart holds on to its muscle glycogen, from which glucose is formed, so tenaciously that all other organs may be depleted before the heart. Further we have learned that the most common cause of dilation of the heart is lack of sufficient oxygen. At 9 vol. per cent the heart dies. The heart is also very sensitive to lactic acid, five times more sensitive than skeletal muscle, so that any excess of lactic acid in the blood reduces the function of the heart, and leads eventually to cessation of beat.

At every systole from 80 to 100 c.c. of blood are thrown out under considerable pressure into an already filled series of vessels. This blood distends the arch of the aorta and during cardiac diastole the recoil of the elastic aorta and large vessels keeps the blood moving towards the capillaries.

There are two fundamental laws of heart muscle which should never be forgotten. One is Bowditch's law that the heart responds to any stimulus with a maximum contraction at the moment of stimulus. The beat may not be forcible if the muscle has just contracted and is in a more or less refractory state, but it is maximum for the muscle at that moment. The other is Starling's law, which is that the strength of a contraction of muscle is dependent upon the initial length of the fibre. In other words, the strongest contraction will be produced by the muscle which is stretched to its physiological limit. If stretched beyond that point chemical changes take place which preclude the return to a former normal state.

The force of the heart depends upon adequate diastolic stretching of the heart muscle fibres. We have long known that the beat following a premature ventricular systole is so strong that the blood pressure of that beat is far above the usual blood pressure and the patient often feels a sensation like a kick in the chest. This is because the lengthened diastolic pause causes increased filling and stretching of the muscle fibres. This is an illustration of Starling's law. It is evident then that sufficient venous return flow from the periphery to the right side of the heart is essential for adequate circulation. A state of affairs where insufficient venous return flow failed to distend the ventricles would result in a more rapid heart rate (in order to maintain cir-

\*Read before the Upper Peninsula Medical Society.



culating blood) with a lessened stroke volume. If less and less blood returns from the periphery, there will finally come a point when there is not enough pressure to maintain coronary circulation, anoxemia of the heart muscle results, dilation takes place and the organism dies. He has bled into his own dilated peripheral vessels.

For years surgeons have talked about shock and much experimental work has been performed in an effort to explain the cause of shock. Most authors now call shock the "shock syndrome." It is generally admitted that the primary condition in the shock syndrome is loss of blood volume. Moon puts it well when he writes: "The shock syndrome results from a disparity between the volume of blood and the volume capacity of the vascular system." Or as Meakins and Long stated in 1927, "Circulatory failure may be defined as a state in which the volume of blood circulated per unit of time is not adequate for the physical needs of the patient." We must keep in mind the important distinction between total blood volume and effective blood volume. Naturally the only portion of the circulating blood which keeps the vital centers alive is the actual effective blood volume. We have known for years that there are large areas in the body, storage depots, where the blood can stagnate or flow so slowly that it is of no use to the organism. In such storage depots the capillaries and minute arterioles and venules hold large quantities of blood. Such areas are the large splanchnic area, the liver itself, the sub-papillary capillary plexus of the skin and the lungs (the last under pathological conditions). In the shock syndrome certain changes are constantly found in the body. These are decreased blood volume, that is concentration of blood in circulation, decreased blood chlorides, decreased venous pressure, insufficient venous return flow.

Let us see now if all these conditions do not occur in so-called heart failure in various severe infections. If you go to your textbooks for help when you have a case of infection with rapid heart, you will find the recommendation to give digitalis in order to stimulate the failing heart. As a consequence every hospital intern (there may now be exceptions) gives some "heart stimulant" to every patient whose pulse suddenly begins to beat rapidly. I submit that the heart does not fail, it is folly to attempt

to stimulate it. What happens is that the peripheral circulation collapses.

Let us take acute peritonitis as an illustration to prove our point, as this disease has been studied experimentally by many investigators. Ten years ago Usadel stated flatly that in purulent peritonitis the heart did not primarily fail but due to vasomotor dilation of splanchnic vessels the patient bled into his own vessels, there was insufficient venous return flow and insufficient stroke volume. Mall many years ago showed that the pressure in the ligated portal vein following electrical stimulation of the intestines was higher than arterial pressure. Some have labeled the intestines the peripheral heart. Now, when meteorism begins, a sudden change for the worse takes place in the circulation and in the general condition of the patient. Histamine-like substances, produced by the action of bacterial toxins upon cells, cause increased capillary permeability, in consequence of which fluid which should remain in the blood vessels transudes into the tissues, causing edema. This decreases the volume of blood in circulation and the oxygen-carrying surface at a time when the body needs all the oxygen it can get. The venous return flow to the right heart is lessened. The body must have oxygen, so the heart speeds up its rate with a smaller stroke volume. The heart actually becomes smaller than normal because it is not stretched during diastole by a normal amount of blood. As the infection becomes more severe there is further transudation into the splanchnic area and then into the lungs. Now the heart is wearing itself out beating against little peripheral resistance and with a decreasing amount of return flow. Finally the circulation pressure is not sufficient to nourish the heart itself through the coronary arteries. Now the heart dilates due to anoxemia (lack of oxygen) and the patient dies. His heart has not failed until just before death.

Every doctor knows what a powerful organ the heart is and what an enormous reserve lies within it. Then how can a previously normal heart fail after a few days illness when it can beat at 120 to 140 beats a minute for months? We never stopped to apply the knowledge gained by the physiologists and the experimental pathologists to the problem and we never stopped to reason the matter out. Usadel further says that the preservation and stimulation of the in-

testinal movements must be viewed as one of the chief demands in the handling of peritonitis cases. "Every attempt to still the intestines caused by fear of increased toxin absorption or spread of the illness to other parts of the peritoneum in the light of the important influence of intestinal movements upon the circulation of the intestine, can be looked upon only as harmful." This is so-called secondary shock, which is not confined to surgical conditions, but which occurs in every serious infection or infectious disease. The principles which underlie the reduction of blood volume, the blood concentration, the loss of blood chlorides, the lessened venous return flow are common to *all* infections of whatever nature—bacterial, protozoal, fungal, or viral.

Let us take another common disease about which there has been no end of dispute concerning the failure of the heart and the use of digitalis, viz.: pneumonia.

There was a time until quite recently when a fierce war of words, backed with many figures and experiments on both sides, was waged by those who believed in giving digitalis and by those who did not believe in its value. The great prestige of the Rockefeller Hospital lent its weight to the digitalis users. To many of us, however, there seemed no logic in its use. Years ago, in 1896, Romberg and Paessler showed that in violent pneumococcus infections experimentally induced in animals, the heart was not functionally below par. Since then Porter and his associates showed that normal hearts perfused with pneumonic blood were just as functionally active as hearts perfused with normal blood. Histological examination of the hearts of those who died of pneumonia have failed to reveal any evidence of specific injury to the muscle cells. On the contrary every case of severe pneumonia (pneumococcus or other bacteria) shows, at autopsy, edema of all tissues, cloudy swelling of all cells and edema of lungs. What do these tissue changes mean? Fluid has transuded from the blood into the tissues due to the damage to the capillaries by the histamine-like substances produced by the bacterial toxins on tissue cells. Indeed the capillary damage is at times so severe that blood passes out into the tissues. Petechial hemorrhages are common autopsy findings. In other words, serious blood volume changes have taken place, venous return flow is lessened, diastolic filling is

decreased, stroke volume is reduced, rapid heart results and finally anoxemia of heart muscle causes dilation and death ensues. Only recently it has been shown by some workers in New York that pneumonia does not bring on heart failure unless the patient is already suffering from heart disease.

More and more workers believe that peripheral circulatory collapse and not failure of the heart is responsible for the appearance of heart failure long believed to be the important point. It will not be long now before sections on treatment in textbooks will be revised.

### Treatment

From what has been said the only logical treatment for failing circulation in infections is to keep the heart filled with blood, to keep adequate diastolic filling. This is no simple matter. If there is a specific anti-serum such as we have in diphtheria or in pneumonia Type I, the administration of this neutralizes the toxins, capillary damage ceases, fluid rapidly re-enters the circulation and normal conditions become established. However, we have very few specific serums so we must resort to indirect means.

The most obvious way is to make use of gravity by elevating the foot of the bed. Obviously this is not feasible in all infections, particularly pneumonia. To this can be supplemented bandaging the legs from the ankles to the hips. This may increase the circulating blood volume, as the legs hold from  $\frac{3}{4}$  to 1 liter of blood. Next we can use oxygen by the nasal catheter method. This is rational in all severe infections for the reasons given above. From 4 to 6 liters per minute should usually be sufficient, but if there is cynaosis of finger nail beds it should be given in amount sufficient to dispel the cyanosis. Oxygen reduces high temperature, slows the pulse and gives the patient a chance to make his own antitoxin.

The next important procedure to keep up blood volume is to give fluids intravenously in sufficient amount. A normal adult loses about 3 liters of fluid per day by kidney secretion, by skin evaporation and by respiration. Water balance must be conserved and chlorides must be balanced. Both dehydration and hypochloremia are serious conditions. We should give normal saline and hypertonic glucose. Normal saline alone has the disadvantage that it leaves the cir-



circulation through the damaged capillaries and further increases tissue edema. The hypertonic glucose tends to draw water from the tissues into the capillaries. Ideally we should use a fluid which has a colloid content so that it will remain for some time within the circulation and assist in maintaining blood volume. Such a fluid is blood. Blood transfusions are not of therapeutic value because they introduce good blood but because they increase blood volume. There is no danger of dilating the heart as the heart is actually contracted. Half a liter of citrated blood may be given at one sitting. The number of transfusions will depend on the severity of the case.

One other colloid substance may be used, that is acacia solution. This appears to be of more value in wound shock with hemorrhage than in the shock syndrome of acute infections.

Lastly, there are drugs, not heart-stimulating but peripheral stimulating drugs. Digitalis was the textbook recommendation. I have said that digitalis is not the drug to use principally because there is no heart failure. Randolph believes digitalis is ineffective, indeed it may be injurious in pneumonia. He believes that the peripheral circulation collapses, the heart does not fail—Wollheim showed that digitalis *decreases* blood volume. Perry says, "Experimental and clinical observations suggest that in the majority of cases of lobar pneumonia both the vasomotor center and the myocardium suffer little damage and yet the patient dies of circulatory failure, failure at the periphery." He does not use digitalis. Niles and Wyckoff at Bellevue Hospital proved to their satisfaction that the use of digitalis in pneumonia was not only useless but actually harmful. Harrison says, "The use of digitalis in persons suffering from peripheral circulatory failure or shock can not be too heartily condemned. Unfortunately many physicians still persist in assuming that the tachycardia and feeble pulse are manifestations of cardiac weakness and continue to give the drug to such patients, who can only be harmed by it." Cole of the Rockefeller Hospital has recently written, ". . . we have discontinued the routine use of digitalis (in pneumonia),

employing it only under conditions, such as auricular fibrillation, where it would ordinarily be employed, even though no pneumonia were present, and then in exactly the same manner."

The drug which I have found most efficacious is strychnine. It has been demonstrated that it increases blood volume, stimulates oxidative processes, increases phagocytosis and very probably decreases capillary permeability. In the condition we are considering a drug with such actions should be valuable. Professor Von Jagic says that he found strychnine the most efficacious drug in the peripheral collapse of influenzal pneumonia. It should be given in doses of 1/30 to 1/15 grain (2 to 4 mgs.) hypodermically every 3 to 4 hours at the first sign of peripheral failure.

Other drugs which seem useful are pitressin and adrenalin. The former has a more prolonged action, the latter has almost too evanescent an action to be useful except where one wishes a quick circulatory response. The dose of pitressin is 1/2 to 1 c.c. hypodermically. The dose of adrenalin, 1:1000 solution, is the same.

We are still awaiting the ideal drug to combat peripheral circulatory failure. Possibly the biochemists will some day discover such a drug. Until we have such a drug we must make out with attempts to increase blood volume, to reduce capillary permeability and to constrict the terminal vessels so that the patient will not bleed to death into his dilated vessels.

### Summary

Enough evidence is brought forward to prove that the so-called heart failure in acute infections is actually the shock syndrome where blood volume changes are the important factor.

Due to insufficient venous return flow the heart speeds up its rate in order to maintain the circulation. The important therapeutic procedure is to increase the circulating blood volume so that there may be adequate diastolic filling. Measures are discussed which have proved useful in treatment.

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Original references of authors quoted may be obtained from the writer. Most of the references will be found in Jour. A.M.A., March 14, 1936.

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DETROIT, MICHIGAN

The age group 21-40 with 181 cases

LICENSED FOR USE UNDER PATENT 1,772,492



## Code for Craniocerebral Injuries

Name of Patient.....  
 Date .....  
 Case Number.....

<b>Service</b>	4.....Poor Cerebration	<b>Deep Reflexes</b>
1.....A	5.....Aphasia	1.....Hyperactive
2.....B	6.....Uncinate Fits	2.....Diminished
3.....C	7.....Astereognosis	3.....Unequal
4.....D	8.....Hemianopsia	4.....Absent
5.....E		<b>Superficial Reflexes</b>
6.....F	<b>Motor Cerebral</b>	1.....Hyperactive
7.....G	1.....Hemiplegia	2.....Diminished
8.....H	2.....Quadriplegia	3.....Unequal
9.....I	3.....Petit mal	4.....Absent
10.....J	4.....Grand mal	<b>Neurological Signs</b>
<b>Date of Admission</b>	5.....Jacksonian	1.....Skull Tender to Percussion
1.....Year	6.....Unilateral Spasticity	2.....Neck Rigidity
2.....Month	7.....General Spasticity	3.....Kernig Positive
<b>Days in Hospital</b>	8.....Unilateral Tremor	4.....Romberg Positive
<b>Race</b>	9.....General Tremor	5.....Babinski Unilateral
1.....White	<b>Sensory Cerebral</b>	6.....Babinski Bilateral
2.....Colored	1.....Paresthesia	<b>Latent Interval</b>
3.....Miscellaneous	2.....Anesthesia	1.....15 min. or less
<b>Sex</b>	<b>Cerebellar</b>	2.....2 hrs. or less
1.....Male	1.....Ataxia	3.....24 hrs. or less
2.....Female	2.....Atonia	4.....1—5 days
<b>Age Groups</b>	3.....Adiadokocinesis	5.....6—30 days
1.....Up to 5 years	<b>Cranial Nerves</b>	6.....31 days or more
2.....6—10	1.....Anosmia	7.....Unknown
3.....11—20		<b>Unconscious</b>
4.....21—40	1.....Diminished Vision	1.....Less than 5 min.
5.....41—60	2.....Retinal Hemorrhage	2.....5 min. to 1 hr.
6.....61 or over	3.....Papilledema	3.....1 hr. to 24 hrs.
<b>Etiology</b>	4.....Optic Atrophy	4.....1—3 days
1.....Automobile	5.....Limitation of Fields	5.....More than 3 days
2.....Falls		6.....Unknown
3.....Penetrating Foreign Bodies	1.....Diplopia	<b>Hemorrhage</b>
4.....Sharp Instruments	2.....Strabismus	1.....Hematoma of Scalp
5.....Blunt Instruments	3.....Unequal Pupils	2.....Extradural
6.....Fisticuffs	4.....Contralateral Dilatation	3.....Subdural Hematoma
7.....Birth Injury	5.....Dilated Pupils	4.....Subdural Hydroma
8.....Miscellaneous	6.....Contracted Pupils	5.....Subarachnoid
9.....Unknown	7.....Fixed Pupils	6.....Subcortical Petechial
<b>Condition</b>		7.....Subcortical Massive
1.....Dazed	1.....Paresthesia of Face	8.....Intraventricular
2.....Restless	2.....Deviation of Jaw	9.....Intracerebellar
3.....Maniacal	3.....Abnormal Corneal Reflex	<b>Hemorrhage</b>
4.....Stuporous		1.....From Ears
5.....Unconscious	1.....Facial Paralysis	2.....From Nose
6.....Shock	2.....Loss of Taste	3.....From Mouth
7.....Alcoholic Breath		4.....Black Eye, Immediate
<b>Symptoms</b>	1.....Tinnitus	5.....Black Eye, Delayed
1.....Headache	2.....Deafness	<b>Skull Fracture</b>
2.....Dizziness	3.....Nystagmus	1.....Linear
3.....Vomiting		2.....Stellate
4.....Irritability	1.....Dysarthria	3.....Basal
5.....Cyanosis	2.....Dysphagia	4.....Compound
6.....Apnea		5.....Comminuted
7.....Stertor	1.....Deviation of Soft Palate	6.....Diastatic
<b>Visible Lacerations</b>		7.....Depressed
1.....Scalp		8.....Frontal Sinus
2.....Frontal Brain		9.....Mastoid Sinus
3.....Parietal Brain		10.....Ethmoid Sinus
4.....Temporal Brain		11.....Sphenoid Sinus
5.....Occipital Brain		12.....Petrous Bone
6.....Cerebellar Brain		<b>Skull Roentgenograms</b>
<b>General Cerebral</b>		1.....Positive
1.....Amnesia	1.....Paralysis Trapezius or Sternocleidomastoid	2.....Negative
2.....Character Change	1.....Paralysis of Tongue	3.....Not taken
3.....Incontinence		<b>Associated Injuries</b>
		1.....Face

2.....Neck	<b>Respirations</b>	5.....Psychoses
3.....Extremities	1.....Above 30	6.....Headache
4.....Chest	2.....Below 14	7.....Dizziness
5.....Pelvis	<b>Cerebrospinal Fluid</b>	8.....Intolerance of Noise
6.....Spine	1.....Clear	9.....Intolerance of Alcohol
7.....Spinal Cord	2.....Bloody	<b>Sequelæ</b>
8.....Ruptured Viscus	3.....Xanthochromic	1.....Visual Disturbances
9.....Peripheral Nerve	4.....Lutic	2.....Auditory Disturbances
10.....Other Associated	5.....Polymorph. increased	3.....Mastoiditis
Injuries	6.....Lympho. increased	4.....Sinusitis
<b>Associated Diseases</b>	7.....Pressure increased	5.....Meningitis
1.....Hypertension	8.....From Ears	6.....Brain Abscess
2.....Kidney Disease	9.....From Nose	7.....Wound Infections
3.....Chronic Alcoholism	10.....From Wound	8.....Disfiguring Scars
4.....Drug Poisoning	<b>Blood</b>	<b>Disability</b>
5.....Tuberculosis	1.....WBC over 10,000	1.....Partial
6.....Diabetes	2.....RBC under 3,500,000	2.....Complete
7.....Syphilis	3.....RBC over 6,000,000	3.....Compensation
8.....Gastro-Intestinal	4.....Hgb. under 70%	<b>Released</b>
9.....Genito-Urinary	5.....Lutic	1.....Other Hospital
10.....Glandular	<b>Treatment</b>	2.....Against Advice
<b>Associated Diseases</b>	1.....Dehydration	3.....Previous Admission
1.....Brain Abscess	2.....Hypertonic Fluids	<b>Death</b>
2.....Brain Tumor	3.....Spinal Drainage	1.....On Admittance
3.....Meningitis	4.....Trepine	2.....Within 1 hr.
4.....Upper Respiratory Infection	5.....Osteotomy	3.....Within 24 hrs.
5.....Other Infections	6.....Debridement	4.....Within 7 days
<b>Blood Pressure</b>	7.....Nasal Feedings	5.....After 7 days
1.....High	8.....Parenteral Feedings	6.....From Complications
2.....Variable	9.....Sedation	<b>Autopsy Cranium</b>
3.....Low	10.....Restraint	1.....Gross Intracerebral
<b>Temperature</b>	11.....Oxygen	2.....Gross Extracerebral
1.....Subnormal	<b>Sequelæ</b>	3.....Microscopic
2.....Over 102° F.	1.....Convulsions	4.....Anoxic Degeneration
<b>Pulse</b>	2.....Nervousness	5.....Museum
1.....Above 120	3.....Irritability	
2.....Below 60	4.....Personality Change	

showed the greatest number of craniocerebral injuries, next being group 41-60 with 156 cases, the other age groups trailing far behind.

There were 417 white and 83 colored. Of these 377 were males; 123 females.

The automobile appears to be by far the largest single cause of injury, there being 227 out of 500 cases. Next come falls with 128 cases; fights and assaults, 100 cases; miscellaneous, unknown included, 45 cases.

The most common condition following craniocerebral injury was unconsciousness, 195 out of 500 cases. One hundred and forty patients showed evidence of alcoholic breath on admission.

Headache was complained of in 97 cases; next in frequency vomiting, 46 cases, and dizziness, 36 cases.

Out of 500 cases 274 showed visible laceration of the scalp; only 1 case showed visible laceration of the brain.

There were 60 cases that showed cranial nerve involvement. Forty-one cases showed pupillary disturbance; 9 unilateral facial weakness; 3 diplopia; 2 nystagmus; 5 other cranial nerve involvement.

Aphasia was present in 4 cases; amnesia in 2.

Reflexes were abnormal in 54 cases.

Twelve had neck rigidity.

Two cases had a latent interval of 15 minutes or less, two a latent interval of 2 hours or less, one more than 30 days.

The length of time of unconsciousness was unknown in 101 cases, but was probably only a few minutes in most of these cases. It was known to be less than 5 minutes in 29 cases, 5 minutes to 1 hour in 59 cases, from 1 hour to 24 hours in 14 cases and from 1 to 3 days in 3 cases.

Thirty-eight patients showed hematoma of the scalp.

There was hemorrhage from the ears in 36 cases.

There was a total number of 49 fractured skulls, of which 40 were linear, 1 stellate, 2 basilar, 3 compound, 1 diastatic, and 2 of the petrous bone. Of the linear fractures, 7 involved the frontal sinus, 3 mastoid sinus, and 7 the ethmoid sinus.

X-rays of the skull were taken in 388 patients, 49 positive, 339 negative. Ten patients of the 49 with fracture of the skull died.

There were associated injuries of the face in 149 cases; of the extremities in 150 cases.

Eighteen cases showed associated dis-



eases, chronic alcoholism being present in 6 cases, 4 had various infections, 2 had hypertension, 2 diabetes, 2 lues, 1 tuberculosis, and 1 kidney disease.

The cerebrospinal fluid was bloody in 15 cases, xanthochromic in 9; there was an escape of cerebrospinal fluid from an ear in 5 cases.

The most common form of treatment appeared to be spinal drainage, 25 cases. Trephine was done in 8 cases, debridement in 3, and osteotomy in 1.

There was a total number of deaths of 41, *i.e.*, 1 on admittance, 3 within 1 hour, 16 within 24 hours, 16 within 7 days, 5 after 7 days.

The above information was obtained by direct compilation of the facts as revealed under each heading on the code sheet. By "cross-compilation" any one heading may be compared with any other heading. Thus, for example, it is easy by means of the machine to find out how many cases with skull fractures involving mastoid sinuses later showed meningitis, or one may study the significance of unilateral dilatation of a pupil by comparing the number of cases with this neurological sign which also showed, say, subdural hematoma either on the ipsilateral or opposite side as the case may be.

## PALLIATIVE SURGERY IN CARCINOMA OF THE STOMACH\*

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The vast majority of cases of cancer of the stomach cannot be offered curative surgery at present because the diagnosis is made too late. It is doubtful, in view of our present knowledge, if this situation will change much for the better because so many lesions develop to the point of incurability before causing symptoms of sufficient moment to bring the patient to seek relief. Until the realization of the hope of some dependable test, possibly biologic, materializes, our greatest problem with these victims of the hidden location of their tumors will be palliation. Of a series of 316 cases which I reviewed in 1936, 51 per cent were clearly inoperable, exploration not being advised, 11 per cent refused operation, 12 per cent had exploration only, 15 per cent were given some type of relief, while only 5 per cent could be given postoperative hope of cure. Of 718 cases reported by St. John, Whipple and Raiford,<sup>8</sup> 98 (12.3 per cent) were resected, 179 (24.9 per cent) had palliative procedure other than resection, and 153 (20.9 per cent) were explored only. The figures of others are generally comparable. While the proportion is small in which real help may be given, the actual number is more impressive when we note that the total number of cases of cancer of the stomach in the United States is estimated at approximately 125,000.

Since this situation exists it means a good deal to the patient to have the best type of palliative operation applicable to his case. He is entitled, not to just some relief, but

to all the relief it is possible to give him. In the following paragraphs the various types of palliative procedures are discussed with abstracts of illustrative cases.

(1) Palliative resection was first done by Pean in 1879, though first successfully accomplished by Billroth in 1881. This is the ideal to be sought, and one should be prepared to proceed with it in any case which merits exploration. If the tumor is in the distal half of the stomach and not fixed to the pancreas by infiltration, resection should usually be undertaken even though regional glands are enlarged and it seems rather certain that metastasis has already made ultimate cure impossible. Posterior fixation should not preclude resection until its nature has been accurately determined, by careful inspection through an incision in the gastroduodenal omentum, to be definitely infiltrative. Often such attachment will be found due to non-malignant adhesions, and separation safe. An involved portion of the transverse colon may occasionally be successfully add-

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Note: Some of these patients were operated upon at the Detroit Receiving Hospital, the others in private hospitals.

ed to the resection. Any patient who cannot be proven inoperable without exploration may be said to be a reasonable risk for palliative resection, particularly when the otherwise hopeless situation is considered.

The patient whose primary growth has been removed is henceforth free from gastric symptoms, often gains weight for a time, recovers from his secondary anemia, and certainly lives longer because his primary lesion is no longer present.

*Case 1.*—B. J., a woman aged forty-nine years, gave a three months history of increasing stomach trouble and of vomiting blood the day before admission. There had been a weight loss of 90 pounds. The x-ray findings were those of advanced carcinoma of the prepyloric portion without fixation. Metastasis could not be proven.

Operation was done October 20, 1933. Involvement of most of the lesser curvature was found. There were large, hard glands in all regional lymph groups but no discoverable visceral metastasis. A high subtotal resection was done together with all regional lymph glands. Five of these glands were sectioned and all showed cancer cells. The patient was seen at intervals of from one to three months during the first year. October 22, 1934, a progress note says: "Symptom-free. Has gained weight steadily." She was not seen for six months and on April 22, 1935, she complained of substernal pain, cough, weakness, and loss of weight, which began three or four weeks earlier. X-ray, May 1, 1935, reported a normal emptying of the remaining portion of the stomach. Decline was rapid and death occurred June 16, 1935.

What may be of greater importance is the fact that the further we extend our indications for resection the less apt we are to leave a lesion which is still confined to the stomach, the fixation and enlarged regional glands being entirely due to inflammation. Horsley<sup>3</sup> cites the report by Margaret Warwick, who found the disease still limited to the stomach in 23% of 176 necropsies on patients who had died from cancer of this organ.

*Case 2.*—C. Y., forty-eight years of age, had complained of weakness, pallor, and loss of weight for nine months. He improved temporarily on ventriculin and iron. Following the vomiting of blood, x-ray studies, which six months earlier had revealed no lesion, showed extensive deformity of the stomach of questionable resectability.

At operation, December 29, 1931, a very large mass (12 cm. in diameter as measured in the laboratory) was found in the distal half of the stomach. Regional glands were greatly enlarged but no gross visceral metastasis could be determined. Adhesive attachment to the pancreas was divided and a high subtotal resection with Billroth I reconstruction was done for palliation.

He has recovered his normal weight and strength. The blood picture is normal. Repeated x-ray checks of the stomach have been negative. Clinically, he is perfectly well seven years since the operation, which was expected to give only temporary relief.

(2) Exclusion of the growth surely ranks next to resection as a measure of relief. Pack and Scharnagel<sup>6</sup> were able to find no earlier record of this operation than that of Parlavecchio<sup>7</sup> in 1910. It has since then been insufficiently emphasized in the literature. In this procedure the stomach is divided transversely above the tumor, the proximal end of the distal segment is closed, and continuity of the proximal portion of stomach with the jejunum restored by end-to-side anastomosis. The local indications are a non-resectable growth situated low enough to allow division and closure of the stomach above it.

The degree of palliation is nearly equal to resection so far as digestive symptoms are concerned, though not for length of life. The tumor is almost as completely isolated from the gastro-intestinal tract as though it were removed. Inflammation about it has opportunity to subside. Food enters a portion of stomach free from disease, gastric digestion and emptying are not interfered with by an infiltrated, often ulcerating area, the appetite is better, there is freedom from pain, and furthermore, the lesion being placed at rest probably develops less rapidly and is not so apt to bleed or to perforate. Finally, the mortality rate is lower than in simple gastro-enterostomy.<sup>6</sup>

*Case 3.*—H. S., a man seventy-five years of age, had had increasing gastric symptoms for six months. Nausea and vomiting were followed later by epigastric pain. Weight loss was considerable. There had been swelling of feet and legs for several months.

X-ray study revealed evidence of a carcinoma involving the distal third of the stomach on the greater and lesser curvature sides. The extent of invasion indicated that resection might be possible. An advanced myocarditis was present.

At operation, January 23, 1937, the pathology was found to correspond to the x-ray findings. In addition, there was extensive involvement of retroperitoneal glands. The pancreas was invaded. No metastases were visible, or palpable in the liver. An exclusion of the growth was done.

Recovery was smooth. He left the hospital February 12, taking and enjoying a full diet without limitation. He remarked that he had not enjoyed eating so much in years. He lived about seven months, during which time he was able to eat, without discomfort, anything he desired.

(3) Gastro-enterostomy was first performed by Anton Wolfer in 1881, and for carcinoma of the pyloric end of the stomach. It is still the most commonly performed palliative operation although it runs a poor third in attaining the end in view. The lesion remains in the alimentary stream to be irritated by contact with food. Bleed-



ing and pain therefore continue. Secondary anemia is progressive. Foul materials from the ulcerated area mix with food, causing a bad taste and poor appetite. Secondary gastritis is only partially relieved at best and interferes with the digestion and function. In order to get well away from the cancer the stoma must often be placed so high that it will empty the stomach poorly. The first result of this is that healing is apt to be incomplete, with leakage and death from peritonitis. This has much to do with the fact that the mortality rate in gastro-enterostomy for cancer of the stomach is out of all proportion to the relative simplicity of the operation and to that of the same operation in benign ulcer. Bull<sup>2</sup> reported a rate of 21 per cent, and ours was 31 per cent. Pack and Scharnagel<sup>6</sup> say the mortality rate is almost as high as in resection. Lahey, Swinton and Peelen<sup>4</sup> reported 40 per cent mortality in palliative operations exclusive of resection. Newberger<sup>5</sup> gives a rate of 50 per cent in comparison to 44 per cent for resection. Then should healing occur, there still remains the large pouch below the stoma where food will collect, exaggerating the difficulties already mentioned and giving the patient little opportunity to gain strength or obtain relief from gastric symptoms. Finally, when successful, it must always be feared that as the tumor continues to grow it will reach the stoma to cause obstruction again and the patient must die with the symptoms from which his operation was supposed to give him freedom.

*Case 4.*—M. S., a man fifty-eight years of age developed obstructive symptoms about three months before admission, after having increasing gastric symptoms for nine months. He had lost about 60 pounds in weight. Metastasis could not be proven. X-ray examination showed an obstructing pre-pyloric lesion with moderate fixation. Except for loss of weight his condition was fairly good.

Operation May 10, 1937, disclosed a carcinoma infiltrating the pancreas with very large retroperitoneal nodes. A high exclusion could have been done, but the patient's poor condition under anesthesia seemed to indicate the shortest possible procedure. A posterior gastro-enterostomy was done.

The immediate result was good. He left the hospital eating better than for years, according to his statement. Soon after going home he developed pain after meals, his appetite became poor and death occurred three months after operation.

This case well illustrates the meager relief which so often follows an operation which does not place the lesion outside the food path.

*Case 5.*—O. A., a man forty-five years of age, had started with vague stomach trouble six months

prior to admission. Vomiting became an increasing symptom during the last six weeks. The thirty pound weight loss had nearly all occurred since the onset of obstructive symptoms. The general condition was quite good. X-ray examination showed an obstructing new growth involving the pylorus.

Operation was performed May 6, 1921. A tumor about three inches in diameter involved the stomach at the pyloric end. It infiltrated the pancreas. Regional nodes, including some retroperitoneally, were enlarged and firm. A posterior gastro-enterostomy was done.

For four months relief was practically complete. Then vomiting recurred. He begged to be operated upon again, not being able to understand that what we had done once we could not do again.

While the results of gastro-enterostomy in this patient were unusually good while they lasted, it did not prevent a recurrence of obstruction. There is no doubt but that this man would have been spared much toward the end if he had had an exclusion.

In most cases where a gastro-enterostomy will work well an exclusion can be done with little more risk and more certain results. Balfour<sup>1</sup> says, "Gastro-enterostomy is usually of little benefit, and should marked or prolonged improvement follow this operation, it would constitute evidence that the growth probably could be removed." We should add "or excluded." William Mayo has said that gastro-enterostomy allows the patient to live longer and suffer more. The type of case in which this operation is indicated is one in which the tumor is relatively small, highly obstructive, with extension or metastasis indicating early termination of life at best.

*Case 6.*—F. D., a man, sixty-six years of age, developed practically complete pyloric obstruction while undergoing treatment for an enlarged prostate, thought to be malignant. His general condition was poor, but he wanted relief from vomiting if that was possible.

On February 18, 1936, under local anesthesia, a tumor three inches in diameter was found to be densely infiltrating the pancreas and to have metastasized to the liver. A posterior gastro-enterostomy was done. Vomiting ceased and in a few days he was taking nourishment freely. Two weeks later the carcinoma perforated into the lesser cavity (autopsy) and death ensued promptly.

Mention should be made here of a two-stage procedure consisting of a primary gastro-enterostomy followed by resection as soon as the patient recovers sufficiently, if he does. This is still being theoretically advised, but I am convinced it is not based upon experience. It partakes of all the pitfalls of gastro-enterostomy with an even higher mortality because of the necessarily high location of the stoma. Any patient on whom a resection can justly be contem-



plated can have it started as an exclusion, leaving closure of the distal end containing the cancer until after the proximal end has been attached to the jejunum. If at this point it seems wiser to proceed in two stages, the lower portion of the stomach can be quickly closed, to be removed later much more easily than had gastro-enterostomy alone been done. I do not believe that gastro-enterostomy should ever be done as a first stage procedure with or without the idea that if the patient ever gets in shape for resection, which he probably will not, he has nevertheless been given good palliation.

(4) So far it is evident that we have been speaking only of lesions in the distal portion of the stomach, which is fortunately the most frequent location. When the cardiac end is involved the problem is quite different. Since the difficulty here is not getting food from the stomach into the intestine, but into the alimentary tract below the cardia, gastrostomy long seemed to be the natural solution. Pain following introduction of food, leakage about the gastrostomy tube with skin irritation around it, and the rapid deterioration of the patient showing little if any help from the operation should thoroughly discourage its use.

The operation giving greatest and surest palliation in this tragic situation is permanent jejunostomy. A very satisfactory type is that of Mayo Robson, in which the jejunostomy is placed at the top of a loop, both limbs of which have been connected by lateral entero-enterostomy, the tube being carried 8 to 10 inches down the distal limb. Maydyl's plan of dividing the jejunum, anastomosing the end of the proximal to the side of the distal loop four or five inches below the point of division and bringing the free end of the distal loop through the abdominal wall to carry the catheter works well. These methods have seemed to me preferable to that of Von Eisberg and Witzel, which theoretically at least might be followed by duodeno-jejunal stasis, as well as difficulty in permitting the catheter to be replaced. After either of these procedures the stomach may be placed completely at rest, pain is relieved, there is no skin irritation from leakage and the patient can be adequately nourished. Some patients are

again able to take food by mouth in comfort after several days, due no doubt to reduction in inflammatory reaction about the tumor as a result of rest. Jejunal alimentation has been well discussed by Wolfer,<sup>9</sup> who gives the formula used for this purpose prepared by Ivy.

*Case 7.*—P. McN., a man sixty-eight years old, had had increasing difficulty in swallowing for ten weeks with recent development of pain on attempting to take nourishment. He had lost 60 pounds. X-ray revealed an extensive lesion of the cardia. Exploration and permanent jejunostomy November 29, 1935, produced a remarkable change in this patient. He was free from discomfort and actually gained weight on his jejunal feedings which he took with great glee. Death did not occur until March 19, 1936.

In our judgment mere obstruction to the passage of food is not sufficient indication for operation. The pangs of hunger do not torture these patients as they do the healthy person deprived of food. So long as fluids can be taken with reasonable comfort the surgeon has nothing to offer. Pain on attempt to swallow liquids constitutes the one indication for this operation.

### Conclusions

1. Each patient should be given not just some relief but all it is possible for him to have.
2. The indications for resection should be extended. Posterior attachment and regional metastasis should not preclude it.
3. Gastro-enterostomy should be replaced by resection or exclusion in most cases. It should never be done as the first stage of a two-stage resection.
4. Permanent jejunostomy should entirely replace gastrostomy in lesions of the cardiac end of the stomach.

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## CHRONIC ENCEPHALITIS\*

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Soon after the epidemics of lethargic or von Economo's encephalitis which occurred between the years 1917 and 1920, it was noted that many patients who had had the disease developed a syndrome suggesting and at times indistinguishable from Parkinson's disease. This condition was classified in various ways by different observers, but was usually referred to as a sequel or residual of the acute encephalitis, as a post-encephalitic syndrome or as a metencephalitis, using a name comparable to the term *metasyphilis*, which has been used for late complications of lues.<sup>22</sup> While many sequelæ of the acute infection such as tics, spasms, myoclonias, athetoses, convulsions, disturbances of sleep rhythm, narcoleptic attacks, conduct disorders, respiratory disturbances and oculogyric crises were described, the symptoms suggesting paralysis agitans were the most common and usually accompanied these other manifestations.

From time to time it has been noted, however, that symptoms suggestive of Parkinson's disease have developed in relatively young individuals who lacked a definite history of a previous encephalitis. The term juvenile paralysis agitans was suggested for some of these cases,<sup>10</sup> but it was often difficult to differentiate cases of juvenile or adult paralysis agitans from those considered to be residuals of acute encephalitis. Burr called attention to this in 1925 when he reported five cases which he felt presented sequelæ of epidemic encephalitis but gave no history of a preceding acute illness.<sup>3</sup> He proposed the term chronic encephalitis for this syndrome.

As patients with parkinsonian manifestations are now being seen with increasing frequency, especially cases lacking a definite history of encephalitis, it was thought worthwhile to review those seen in the University Hospital during the year 1937. The enclosed table (Table I) shows the distribution of these cases. Out of a series of ninety-two patients, thirty-four, or 37 per cent, can probably be classified as having true Parkinson's disease. The onset of symptoms occurred between the ages of fifty-three and seventy-six, averaging 63.35 years, and every patient showed some of the so-called stigmas of senility or degeneration, such as arteriosclerosis, hypertension, arteriosclerotic or hypertensive heart disease, diabetes, hypertrophic arthritis, cataracts or prostatic hypertrophy. As is the case

in true paralysis agitans, the male sex predominated, and in this series there were twenty-five males to nine females. A total of seventeen cases, or 18.4 per cent, gave a history either of epidemic encephalitis or of certain of the manifestations frequently considered to be part of the picture of encephalitis—insomnia, prolonged sleep, inversion of the sleep cycle, epidemic hiccough, acute psychic disturbances, etc. The onset of the disease occurred between the ages of four and thirty-seven, averaging twenty-one years. The symptoms of parkinsonism became evident at varying periods of time, coming on as the amyostatic or hyperkinetic manifestations of the acute illness, immediately after the acute illness, or as long as nine years later. The average time of onset was 2.24 years after the original infection. In this group the males and females were more evenly divided; there were nine males and eight females.

Many of the patients who give no history of acute encephalitis do give a history of other acute illnesses preceding the onset of symptoms. Eight patients, or 8.7 per cent, gave a history of having had "influenza," but as the patient's own diagnosis usually has to be accepted, and as it is extremely difficult, in a history, to distinguish between true epidemic influenza, grippe and simple respiratory infections, the value of this history often is doubtful. The illness varied in these cases from fairly benign attacks in most instances to relatively severe illnesses, with or without prolonged fever and delirium. There were six males and two females in this group. The original illness occurred between the ages of twelve and fifty years, and the parkinsonian manifestations, which came on gradually in most cases, became noticeable at varying time intervals up to thirteen years later. Three patients, 3.3 per

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cent, gave a history of pneumonia preceding the onset of symptoms. In two of these the illness was rather severe and was accompanied by delirium. The symptoms became

group has been divided into two sub-groups. In the doubtful cases there were six males and four females in whom the symptoms became evident between the ages of forty

TABLE I. PATIENTS PRESENTING PARKINSONIAN MANIFESTATIONS  
Jan. 1-Dec. 31, 1937

Classification	Number of Patients	Per Cent	Average Age at Onset (Years)	Average Interval Between Illness and Development of Parkinsonism (Years)
"Parkinson's disease"	34	36.9	63.35	
History of encephalitis	17	18.4	21	2.24
History of other illnesses and infections				
"Influenza"	8	8.7	28.6	5.38
Pneumonia	3	3.3	20.7	4.7
Acute delirium	2	2.2	9.5	Gradual onset
Scarlet fever	1	1.1	16	Gradual onset
Typhoid fever	1	1.1	18	5
Postoperative	3	3.3	31.3	
Postpuerperal	1	1.1	17	Gradual onset
Total	19	20.8		
Negative History				
Ages 40-55 years	10	10.87	49.1	
Ages 6 months - 39 years	12	13.03	26.87	
Total	22	23.9	36.98	

evident three to six years later. Two patients, 2.2 per cent, showed a gradual onset of symptoms after an undiagnosed illness characterized by fever and delirium. One patient noted the gradual onset of symptoms following scarlet fever at sixteen; one noted their onset five years after an illness diagnosed as atypical typhoid fever. In three patients the parkinsonian syndrome became manifest post-operatively—in one immediately after an appendectomy at twenty, in one a year after an appendectomy at eighteen, and in one gradually after a hysterectomy at fifty-six. In one patient the symptoms became noticeable soon after a pregnancy.

The last group of cases, those developing parkinsonian manifestations but showing no stigmas of senility and presenting no history of encephalitis, acute infectious processes or exposure to toxic substances, numbers twenty-two patients, or 23.9 per cent of the total. The age at the time of onset in this group varies between six months and fifty-five years, averaging 36.98 years. In order to eliminate any possibility that some of these patients may present early manifestations of true Parkinson's disease, the

and fifty-five, averaging 49.1 years. In the remaining group there were twelve patients varying between the ages of six months and thirty-nine years at the time of the onset of symptoms, the average age being 26.87 years.

### Interpretation

An appraisal of these statistics leads one to the conclusion that parkinsonian manifestations occur not only during the involutional period of life but may become manifest at any age, and that they occur not only as a sequel to acute encephalitis but also after other illnesses and infections. Also, there is a fairly large group of patients in whom there is no history of a preceding illness. Oppenheim stated that paralysis agitans is a disease of *old age*, usually occurring during the sixth decade, occasionally in the fifth, cases being rare under forty. "Its onset in youth is an extremely rare occurrence, and such cases ought to be diagnosed with great reserve."<sup>18</sup> Gowers stated that two-fifths of the cases came on between fifty and sixty, one-fifth between forty and fifty, and one-fifth between sixty and seventy.<sup>7</sup> Willige, in 1911, collected all the



cases recorded since 1850 in which paralysis agitans began before the thirtieth year; he was able to find only twenty cases, and in these the earliest age of onset was eighteen to twenty years.<sup>24</sup> It has been since the advent of encephalitis in epidemic proportions that paralysis agitans has become frequent in the younger age groups, where formerly the manifestations were sufficiently rare to warrant special case reports.

Epidemic encephalitis is a disease whose etiology and epidemiology is not entirely understood.<sup>1,13,15</sup> It is presumably a virus disease, but only in certain sub-groups, such as the St. Louis or Japanese variety, has the specific virus been found.<sup>9</sup> Due to the close temporal relationship between the great epidemics of influenza at the close of the late war and the early epidemics of encephalitis, it was originally thought that the two conditions had a common etiology. It is now felt, however, that the relationship was coincidental, and that there is no definite evidence that encephalitis is caused by a neurotropic influenza virus. Hurst states, "The evidence fails in any particular to indicate a common entity for influenza and epidemic encephalitis. It fails to indicate that the presence of influenza predisposes to encephalitis, either in the mass or in the individual. The cases diagnosticated influenza at the time of onset in an epidemic which later require correction of diagnosis to encephalitis are extremely rare."<sup>11</sup> Neal states that the diagnosis of influenza is often loosely made, but that since the discovery of the virus of influenza the diagnosis can be made with a high degree of accuracy.<sup>16</sup> From a study of patients with nervous system disease for the presence of antibodies protective against influenza, she concludes that there is no relationship between encephalitis and influenza, and that any apparent connection between these two diseases is purely fortuitous.

The development of symptoms after months to years of normal health following the apparent complete recovery from acute encephalitis, or their recrudescence in apparently static cases, leads one to believe that the disease is a chronic, progressive process, and that the virus may lie dormant for long periods of time, later giving rise to a more degenerative process than was seen in the acute disease.<sup>2,5</sup> Postmortem observations confirm this impression.<sup>8,17,23</sup> Consequently the parkinsonian syndrome is now regarded

not as a sequel of acute encephalitis, but as a manifestation of chronic encephalitis. Wimmer has stated, "Not very long after the extensive outbreaks of epidemic ('lethargic') encephalitis it was noticed that, following the acute stage of the disease, a series of nervous disturbances, often extremely tenacious and deleterious, would frequently persist. While, at first, there was a tendency to regard these nervous cases as 'sequels,' reliqua, following an acute but in itself abated inflammatory affection of the central nervous system, numerous experiences gained during later years have forced the view upon us that the encephalitic process may remain active for years within the central nervous system as an intermittent or recurrent process which, however, in by far the majority of cases, is of a progressive nature."<sup>25</sup> Riley has also stated that the term *sequelæ* is not a good one, as the modern conception of the disease is that of a relentless, continuing process, successively destroying one function after another. He feels that the disease process may flare up after months or years, not as a fresh attack, but as a resurgence due to the persistence of the causative factor.<sup>19</sup>

It is apparent that syndromes similar in every respect to those seen in the chronic stage of epidemic encephalitis may also follow other acute infections, such as pneumonia and scarlet fever. Those patients experiencing prolonged fever and delirium, whatever the associated infection, may very possibly have suffered with an acute encephalitic process, the pathologic changes in the central nervous system probably not being specific for any one type of encephalitis. It is a little more difficult to evaluate the parkinsonian manifestations which have been reported following trauma, operations, pregnancy, et cetera. It is known that certain toxins, such as carbon monoxide and manganese, may result in syndromes of this type, and as nitrous oxide has also produced degenerative changes in the basal ganglia,<sup>14</sup> one must consider this as a potential factor in those cases in which the symptoms have developed following a major operation. In most of the cases in this group, however, it is necessary to appraise the history carefully.

In our series of cases, and this is no doubt true in every series, there is a large group of patients who give no history of any acute episode. It may be that some of these pa-



tients had an acute encephalitis without clinical signs, but undoubtedly more of them had abortive infections during which the virus entered the nervous system only to remain dormant for varying periods of time, later giving rise to a progressive degenerative process or to acute recrudescences.<sup>6,21</sup> The onset of the illness may have been so mild, so insidious, that the patient himself was not aware of it.<sup>26</sup> This phenomenon, of course, has been described before. Wimmer stated that in only a minority of his cases was he able to obtain a history of fairly typical encephalitis, and that many of the cases are chronic and insidious from the beginning and fail to show a classic infectious phase. Economo, in discussing the parkinsonian manifestations, states, "These treacherous 'sequelæ' may even develop without any acute stage of encephalitis lethargica. In this case the original attack may have been an unnoticed 'forme fruste' in the course of an epidemic, or an overlooked influenza-like prodromal stage, or it may have been that, in some cases, the virus reached the central nervous system without producing any acute manifestation, and slowly continued its destructive activities there until the clinical symptoms actually appeared."<sup>22</sup> He feels that the manifestations of chronicity may be residuals or evidences of prolonged convalescence, but that frequently one sees purely chronic cases, the symptoms being due to the reactivation of the dormant virus, fairly often with no history of a previous acute phase.

When one excludes the factor of age, the differentiation between Parkinson's disease and the parkinsonian manifestations of chronic encephalitis is an extremely difficult problem. A history of sleep disturbances, delirium, hyperkineses, eye muscle disturbances, paralyses, changes in the reflexes, etc., is of value in arriving at a diagnosis, but often chronic encephalitis can be diagnosed on the basis of the youth of the patient, the relatively rapid development of symptoms, the development of rigidity and masking of the face in advance of disturbed motility, the history of sudden advances rather than gradual progress, or the presence of respiratory disturbances, mental symptoms, "greasy face," sialorrhea, et cetera. It has been observed in our cases that all of these manifestations, as well as such symptoms as oculogyric crises, narcoleptic spells, myasthenic manifestations, et cetera,

occur as frequently in those patients who give no history of acute encephalitis as in those who do. As a further diagnostic criterion, the parkinsonian manifestations of chronic encephalitis show a much better therapeutic response to drugs of the scopolamine, stramonium, atropin group than do those of paralysis agitans. These drugs are of more value in the relief of the rigidity than of the tremor, but are of some value in both, and the more recent addition of benzedrine to the drugs of this group has in certain cases relieved the tremor as well, and has been especially effective in stopping the oculogyric crises.<sup>4,20</sup> One must admit, nevertheless, that a clinical differentiation between chronic encephalitis and Parkinson's disease is often impossible. The following case report emphasizes this:

#### Report of Case

R. L., a man aged sixty, was admitted to the University Hospital on August 2, 1937. Seven years before he had noticed the onset of weakness of the back, rigidity of the extremities and loss of associated movements in walking. There was no history of encephalitis, fever or delirium, or of exposure to toxins.

*Examination.*—The patient was an elderly white male. There was rigidity of upper and lower extremities with contractures of the fingers and wrists. The facial expression was mask-like. There was a greasy seborrhea over the forehead. The pupils reacted normally. There was moderate arteriosclerosis of the retinal vessels. The tendon reflexes were about normal and no pathological reflexes were elicited. The blood Kahn test, urinalysis and blood count were all normal. Spinal fluid pressure was 150 mm. of water. Examination of the fluid showed no cells, and the Kahn, colloidal gold and mastic tests were negative.

*Course in the hospital.*—The patient was moribund at the time of admission. Hyoscine was used in an attempt to reduce the rigidity, but the patient had a low tolerance for the drug and became delirious. He was given palliative care, but died of bronchopneumonia on September 14, 1937.

*Pathologic examination.*—The gross pathologic diagnoses were bronchopneumonia, generalized arteriosclerosis and arteriosclerotic nephropathy. Examination of the brain showed no gross changes. The basal ganglia were of normal size and were well outlined. The red nuclei were distinct but appeared to be pale. The substantia nigra also appeared pale. Histologic examination of the brain showed moderate arteriosclerosis. No senile plaques were seen. Nissl sections revealed the presence of marked glial changes in the substantia nigra with loss of parenchymal elements.

In this case the clinical diagnosis was Parkinson's disease of the idiopathic or arteriosclerotic variety, while the pathologic picture showed changes typical of chronic encephalitis. Certain observers have been impressed by the impossibility of differentiating parkinsonian manifestations of the idiopathic, arteriosclerotic or encephalitic



variety on the basis of clinical examination alone, and feel that a conclusive diagnosis can be made only if the history, symptomatology, clinical course and pathologic findings are all taken into consideration.<sup>12</sup>

### Conclusions

1. Parkinsonian manifestations should not be considered to be sequelæ or residuals of an acute encephalitis, but to be manifestations of a chronic, persistent infectious process.

2. Chronic encephalitis with parkinsonian manifestations may occur in patients who give no definite history of a preceding acute encephalitis.

3. The clinical differentiation between chronic encephalitis and Parkinson's disease is often difficult to make.

4. In view of its increasing frequency, chronic encephalitis should be considered to be one of the more important of the organic diseases of the nervous system.

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### Alcohol in Relation to Traffic Accidents

RICHARD L. HOLCOMB, Evanston, Ill. (*Journal A. M.A.*, Sept. 17, 1938), reports the results of a study of the drinking of drivers involved in personal injury accidents and of the drinking of drivers in the general population. The second study served as a control of the first, allowing conclusions to be drawn as to the part alcohol plays in accidents. A total of 270 persons were tested in the first study. Drivers involved in personal injury accidents who accompanied the persons injured to a hospital or drivers who themselves were injured were tested by urinalysis for alcohol. A total of 1,750 persons were tested in the second study. Drivers were chosen at random from an area comparable to that of the first study. A complete testing laboratory, with the Harger "drunkometer," was set up in the trailer, allowing breath tests for alcohol to be made immediately. 1. The highest percentage of drinking drivers occurs in the early morning hours and over the week-end. 2. The largest number of drinking drivers occurs in the early evening and over the week-end. 3. The peak age for drinking drivers is

from 25 to 30. 4. Women drink and drive as much as men when the number of women driving at various hours of the day is considered. 5. The percentage of drinking drivers in the general population varies as does the percentage of drinking drivers in the personal injury accident group but falls considerably lower at all times. 6. The percentage or number of drivers involved in personal injury accidents varies as does the percentage or number of drinking drivers. 7. As the blood alcohol content increases, the number of drivers appearing in the personal injury accident group increases out of all proportion over that in the general driving population. 8. As alcohol increases, accidents increase and at a rate somewhat proportionate to the increase in alcohol. 9. Equal percentages of drinking drivers are found in the accident group and in the general population group at a point near 0.5 part of alcohol per thousand parts of blood, indicating that alcohol in that amount is not necessarily a significant cause of accidents. 10. The data gathered in this study confirms a self-evident fact, that alcohol is a major cause of automobile accidents.

# ACUTE YELLOW ATROPHY OF THE LIVER CAUSED BY POISONOUS MUSHROOMS

## Report of Cases

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While mushroom poisoning is quite frequent in Europe, it is relatively rare in the United States. Especially in France, where the nourishing value of mushrooms is greatly emphasized, and, probably, overemphasized, many cases have been reported. Ford<sup>1</sup> collected 990 cases from the French literature, 318 having been fatal. In the German and Austrian literature he found reports of 171 cases, with forty-nine deaths.

Of the great number of poisonous mushrooms, those belonging to the *Amanita* group are most important, *Amanita Phalloides* being by far the most frequent cause of severe poisoning. According to Vander Veer and Farley,<sup>7</sup> this fungus was involved in 90 per cent of the cases of fatal mushroom poisoning. Ford found that out of the 1,161 cases of mushroom poisoning collected from the French, German and Austrian literature, 661 were due to *Amanita Phalloides*. The total mortality in these 1,161 cases was 367 (31.6 per cent), while the 661 cases of *Amanita Phalloides* poisoning gave a mortality of 306 (46.2 per cent).

Liver damage was observed in numerous cases of mushroom poisoning reported in the literature. Vander Veer and Farley report four cases of *Amanita Phalloides* poisoning, two of which showed advanced destruction of the hepatic tissues. The others recovered, but had shown definite clinical signs of involvement of the liver. Six fatal cases of *Amanita Phalloides* poisoning, reported by Herzog,<sup>3</sup> showed marked fatty changes in the liver with slight necrosis and some regenerative changes. Petri<sup>4</sup> found all stages of damage of the liver in thirteen cases of mushroom poisoning, six of which were proven to be caused by *Amanita Phalloides*. Tappeiner<sup>6</sup> points out that the changes in the liver in these cases are very similar to those seen in acute yellow atrophy, while Prym<sup>5</sup> sees no difference between the conditions at all.

The first signs of the poisoning usually occur after most of the poisonous material has passed the stomach, seldom less than five, sometimes up to fifteen and twenty, hours after ingestion. Signs of severe gastrointestinal disturbance are the most outstanding symptoms: profuse vomiting, diarrhea, and extreme abdominal cramps. Anuria is frequently observed, jaundice might devel-

op. Gore and Tracy report muscle cramps, twitchings, loss of motor control and disturbances of vision. The course extends over six to eight days. In the non-fatal cases the symptoms subside gradually, and the patient recovers completely. In the fatal cases, the patient becomes progressively jaundiced and cyanotic, and dies in coma.

Anatomically two conditions mark the disease picture in fatal cases of *Amanita Phalloides* poisoning: fatty changes in heart, liver and kidneys, and a marked hemorrhagic diathesis. It is characteristic that these two conditions are noted in practically all those cases reported in the literature. Herzog's six cases showed uniformly a great number of petechial hemorrhages which were most marked in omentum and mesentery. The most extensive fatty changes were observed in the liver. Ford estimates the fat content to vary between 50 and 80 per cent.

## Report of Cases

A male patient, fifty-three years old, was admitted to the W. A. Foote Memorial Hospital, Jackson, Michigan, October 16, 1936. Previous history was insignificant. The patient had eaten mushrooms the night of October 12. Although he experienced gastric distress the next morning, he went to work. As he had no relief at noon, he called the doctor, who found him somewhat cyanotic and his abdomen distended. Hot stupes and an enema gave some relief. As his symptoms did not subside entirely after several days he was admitted to the hospital. His temperature on admission was 98, pulse 104, respiration 22. Turpentine stupes gave him complete relief. Shortly afterwards, however, he became markedly cyanotic and expired unexpectedly before physical and laboratory examinations could be carried out. The autopsy was performed two hours after death.

Aut. No. A-3-36.

Abstract from protocol:

Moderate icterus of the skin and sclera. Multiple



hemorrhages were found in the thymus. The heart weighed 290 gms.; it showed a large subendocardial hemorrhage in the septum. The right heart appeared relaxed. Marked pulmonary emphysema and congestion were found. Multiple hemorrhages were

are suspended. There is a necrosis of the cells of the liver of moderate degree. There are some reparative changes indicated by a slight infiltration of wandering cells in the Islands of Glisson and a new formation of bile ducts. *Kidneys* showed



Fig. 1. Liver showing acute yellow atrophy following mushroom poisoning. Early reparative changes in Islands of Glisson. Hematoxylin-eosin stain. Zeiss Planar 20 mm.

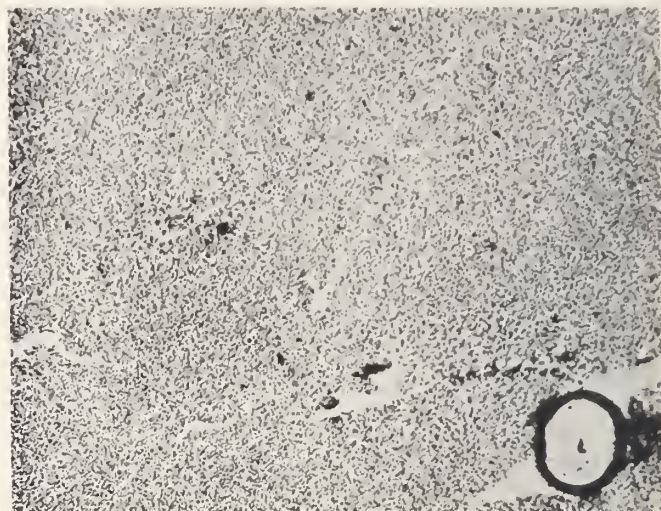


Fig. 2. Same as Figure 1. Sudan III Stain.

found in retropharyngeal and periaortic tissues. An old calcified tubercle was found in the mediastinal lymphnodes. Multiple old tubercles were found in spleen. The intestines showed a great number of recent large hemorrhages at the mesenteric-enteric and mesocolic-colic borders. The mucosa of the entire intestine was somewhat swollen and congested. The liver measured 24x20x10 cms. and weighed 1,450 gms. Its consistency was doughy. The surface was mottled in appearance and smooth. The cut-surface showed alternating brown and yellow areas; a lobular architecture could still be made out in the former, but had entirely disappeared in the latter, areas. The kidneys were relatively small, weighing 107 and 127 gms. respectively. Their cortex appeared distinctly yellow and bulged over the cut-surface. There were petechial hemorrhages in the renal pelvis. The retroperitoneal tissues showed multiple recent hemorrhages.

The microscopic examination showed: Hypoplasia of myocardium, small lymphocytic infiltrations in subepicardial fat and subendocardial hemorrhages. There was marked degenerative fatty infiltration and early coronary sclerosis. The aorta showed early atherosclerosis, "hypoplasia," recent hemorrhage into adventitia. The lungs showed marked acute emphysema, anthracosis, passive congestion and an old calcified tubercle in hilus gland. There were recent hemorrhages in adventitiæ of arteries. *Bronchus:* Active chronic bronchitis. Hemorrhages were found into peribronchial tissues. Examination of the thymus revealed fatty atrophy of a persistent hyperplastic thymus. There were recent hemorrhages into the adipose tissue. *Stomach* showed active and relatively acute gastritis as well as edema of the submucosa. Examination of the *small intestine* revealed active enteritis of moderate degree. In the *large intestine* there was found active inflammation more marked than in small intestine. Hyperplasia of lymphfollicles was noted. *Spleen:* Atrophy. The examination of the *liver* revealed complete destruction of the hepatic parenchyma as well as fatty infiltration of an extreme degree. There was also some degenerative fatty infiltration. In the hematoxylin-eosin stain, the liver appears like a network in which the hepatic cells

marked cloudy swelling, simple necrosis, advanced degenerative fatty infiltration of the renal tubules which is confined to the basal membranes of the tubular epithelium and recent hemorrhages into renal pelvis.

Diagnosis: "Mushroom poisoning." Early sub-acute yellow atrophy of the liver. Marked generalized hemorrhagic diathesis. Degenerative fatty infiltration in myocardium and kidney tubules. Terminal cardio-respiratory death. Active entero-colitis and gastritis. Thymico-lymphatic constitution. Old splenic and mediastinal tuberculosis.

#### Related Case

A day after this patient's admission his wife was admitted to the hospital with symptoms which were very much more severe than her husband's. The morning after the mushroom dinner she started to vomit profusely and had severe diarrhea and abdominal pain which lasted until her admission on October 17. On admission she was very weak and appeared quite ill. She was slightly icteric. There were multiple petechial hemorrhages in the skin of the chest. The abdomen was slightly distended. Blood pressure was 119/60, temperature 98.2, pulse 92, respiration 25. The urine showed continuously a trace of albumen and 4 plus pus. Sugar was also 4 plus, but this disappeared after a week. RBC went down to 3,600,000, Hb to 70 per cent, the WBC was constantly 8,000. The diarrhea ceased soon while the vomiting persisted. Her temperature was irregular, going up to 102. A blood transfusion was followed by a marked improvement in the patient's condition. The icterus disappeared and the vomiting ceased. She was discharged as cured eight days after admission.

#### Comment

The case described above reveals two interesting points: The acute yellow atrophy of the liver caused by a hepatotoxic substance in *Amanita Phalloides*, and a very peculiar discrepancy between clinical and



pathological pictures. That the condition was actually caused by the ingestion of poisonous mushrooms seems beyond doubt, although there was no definite proof. The appearance of symptoms in two members of the same family several hours following a mushroom meal practically excludes any other condition, especially if we take into consideration the fact that the anatomical findings described match entirely those of similar cases reported in the literature. The description of the fungi by the relatives suggested strongly that the poisonous mushroom was *Amanita Phalloides*.

It seems exceedingly difficult to explain the lack of severe symptoms without sufficient clinical information. Sections taken from different parts of the liver show uniformly a complete destruction of functioning hepatic tissue. Evidences of very early repair indicate that the destruction was not immediately followed by death. In spite of the marked anatomical changes, the patient did not show signs of the so-called hepatic coma. The sudden and unexpected death could be explained by the hemorrhage into the interventricular septum found at autopsy.

Anatomically, this case demonstrates three important features. First, the severe change in the liver was the most outstanding finding as the direct cause of death. Second, the hemorrhagic diathesis is a part of the disease picture which was frequently described in the literature in similar cases. The question arises as to whether the hemorrhages were due to the destruction of the liver per se, or were caused by the primary effect of the toxic substance. Hemorrhages were also found in the patient's wife, although she had not shown severe signs of damage of the liver, save a moderate icterus which disappeared after a few days. Considering also the fact that at autopsy most hemorrhages were found at the mesenteric-enteric and mesocolic-colic borders, the site of the absorption of the poisonous substance, a direct effect of the toxin appears most plausible. The third condition was the extensive degenerative fatty changes in kid-

neys and myocardium. These changes were unusually marked in our case and, according to the literature, seem to represent a regular finding in cases of mushroom poi-

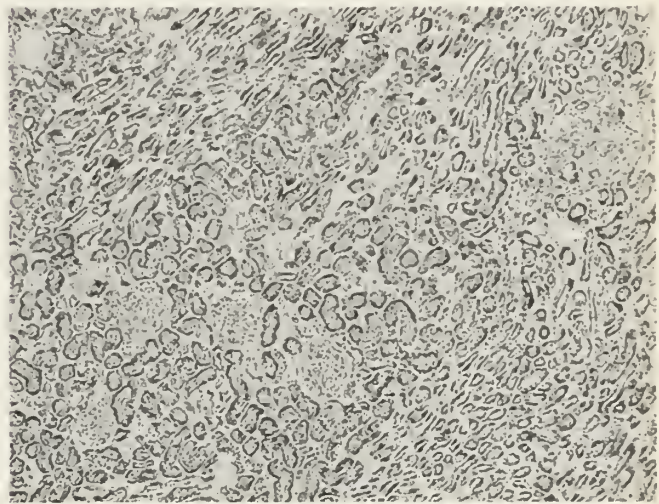


Fig. 3. Advanced degenerative fatty infiltration of renal tubules in a case of acute yellow atrophy of the liver following mushroom poisoning. The fat, appearing black in the photomicrograph, is confined to the basal membranes of the tubular epithelium. Hematoxylin-eosin stain. Zeiss Planar 20 mm.

soning with similar pathology in the liver.

The complete recovery of the patient's wife, in spite of more severe symptoms, indicates that in her case the principal effect of the toxic substance was outside the liver, probably in the intestinal tract only.

### Summary

A case of acute yellow atrophy of the liver due to the ingestion of poisonous mushrooms (*Amanita Phalloides*) is reported with autopsy findings. Besides the changes in the liver, a marked hemorrhagic diathesis and degenerative fatty changes in kidneys and myocardium were found.

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# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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OCTOBER, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### A DANIEL COME TO JUDGMENT

WE ARE in receipt of the *Baltimore Sun* of August 21, which contains a signed editorial by H. L. Mencken on the subject of "Medicine Under the New Deal." Mr. Mencken had written an article which appeared in the same paper on August 5, which evidently did not please those interested in controlling the medical profession. One of the number called on him following the publication of the first article to set him right, and to place before him the "facts." This emissary of the New Deal went on to say that

"The technology of medicine has made its great advances by trial and error; the arrangements under which patients have access to medical services must be kept subject to a like revision. It is silly to encourage experimentation in the medical laboratory and to forbid it in the realm of medical economics."

This fairly represents, we think, the social service or reformer's viewpoint on the subject. Medicine has been so taken up with academic phases, the promotion of high standards of medical service, that it has neglected the means whereby those who need medical service may obtain it. In other words, the manufacturer goes on producing his wares and gives no thought to their distribution. Hence arise a new cult of salesmen or distributors, self appointed, who are going to take upon themselves the neglected task of distribution.

The absurdity of this attitude is apparent to every member of every county or state medical society whose activities have been centered for years on the subject of making scientific medical service available to those in need of such service. The medical journals have contained accounts at great length of schemes that have been put in force by county medical units throughout the United States who have endeavored with greater or less success to meet local needs. The plans adopted from time to time and altered to meet changed conditions are protean. In fact there are registered with the American Medical Association more than 3,500 plans, the purpose of which, among other things, is to effect a wider distribution of medical care among those in need of it.

The medical profession, it goes without saying, refuses to be exploited or to be oriented by any lay group. It is a long story, but in essence, if the doctor is to perform his best services, he must be free.

Mr. Mencken, in the above mentioned article, goes on to say that lawyers have fought and are fighting a prolonged battle against the practice of law by corporations, in order to prevent the deprofessionalizing of law, and he says that "all objections that these decent lawyers have brought against the practice of law by corporations are valid against the practice of medicine by corporations."

Mr. Mencken goes on to account for what he calls a disingenuous assault upon the medical profession. It did not originate, says he, in the department of justice. As to the origin of the furor against medicine, we will let Mr. Mencken tell it since he has expressed the feeling of many in the profession.

"It originated in quite other quarters and has been going on for a long while. There are doctors who aspire to office in the association (A.M.A.), with all the honors and dignities thereto appertaining,

but do not seem to be able to get the necessary votes; they appear to believe that their chances would be better under some sort of medical new deal. And there are quacks who have felt the association's heavy hand; they are against it on all counts and to the death.

"Both these parties have been on the warpath for years. Of late, they have been joined by a miscellaneous rabble of pinks, some of them outright converts to the Moscow hooey and others members of the "I'm Not a Communist—But" Association. The aim of these brethren is to nationalize the profession of medicine in the United States as it has been nationalized in Russia. Some of them say so frankly, and undertake to prove idiotically that the Russian system is better than the American. The rest, less honest, root for it without openly advocating it.

"All the pink weeklies and other manic-depressive sheets are hot against the A.M.A. and belabor it constantly. They denounce it under the name of the medical trust and allege that its members are racketeers who rob their patients and oppress the poor. The justice and decency of these charges may be indicated by putting them into concrete terms. What they allege, in plain English, is that such men as Dr. Thomas S. Cullen, Dr. Dean Lewis and Dr. John T. Finney are racketeers and that scores of able and faithful men and women who labor in the Johns Hopkins and University of Maryland dispensaries every day are oppressors of the poor."

## GROUP HOSPITAL INSURANCE

THE question of what is to be included under hospital care is becoming recrudescient. There are still members of the medical profession who are willing that roentgenology, pathology and anesthesia be included in any scheme of group hospital insurance. Those who advocate the inclusion of these services are apparently unaware that they are making it easy for the inclusion of all medical and surgical services. This is particularly true, if the policy holder likes the sample.

Everyone has a right to his own opinion. We would, therefore, be the last to attack any opponent's position. Voltaire once said, "I do not agree with a thing you say, but I will fight to the last to secure you the right to say it." If those who speak the loudest for the inclusion of such well defined medical specialties as roentgenology, pathology and anesthesia are really favorable to the inclusion of surgery in all its branches including obstetrics, and internal medicine as well, let their position be clear and unmistakable. Everything is to be gained by knowing where the pros and contras stand. If *all* hospitals are to become diagnostic centers, then we will have some situation as follows: The profession will be divided into a very small group of diagnosticians, and a larger group of treaters.

The entire science of medicine has concerned itself largely with the subject of diagnosis. If there has been any advance in the last fifty years, it has been in this direction. Medical colleges have emphasized it in their curricula, we had sometimes thought almost at the expense of treatment. The quack and the irregular practitioner have paid little or no attention to diagnosis and practically all their attention to bizarre forms of treatment. It will be a sad day when the rank and file of practitioners of medicine trained in modern methods of diagnosis admit their inability to go on, and rely on so-called diagnostic centers to perform this important function for them. This would not apply to those sparsely populated portions of the State unable to support a roentgenologist or specialist in clinical laboratory methods. It may develop that such facilities will require to be subsidized inasmuch as they are not entirely self-supporting. Medicine, however, has developed a number of defined independent specialties and its progress has been due in a large measure to concentration by the specialist.

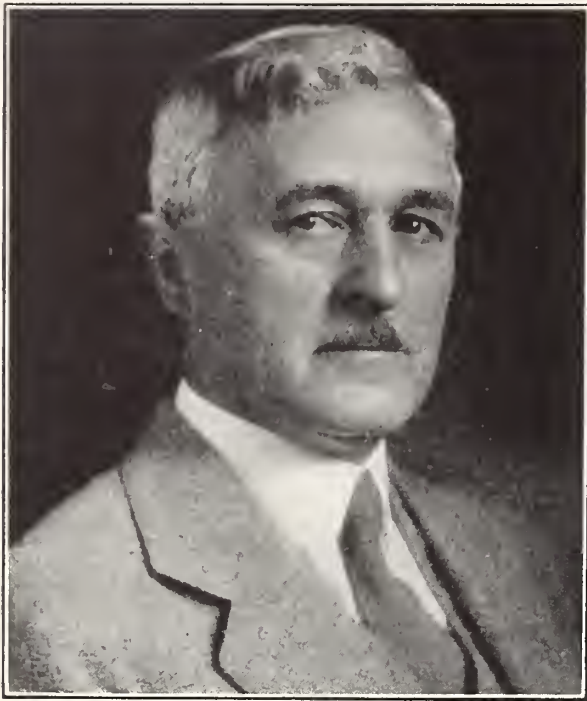
Our plea is that no part of medical care which includes diagnosis and treatment be included in any blanket group hospital insurance plan. It is in the interest of every member of the profession to preserve the integrity of every legitimate specialist group within the profession. In this way only can the continued progress in all that goes to make the high standard of medical care possible, be assured.

## DR. LUCE, PRESIDENT

DR. HENRY A. LUCE of Detroit, president-elect of the Michigan State Medical Society a year ago, has assumed the rôle of president. Dr. Luce comes to the position after a long and varied experience in medical affairs. He was president of the Wayne County Medical Society in the year 1925-26. He has been a delegate to the Michigan State Medical Society for about twelve years and has occupied the position of speaker of the House of Delegates in the session 1934-1935. Dr. Luce has been a member of the House of Delegates of the American Medical Association for the fifth term. In the national body, he has given good account of himself. His services have been recognized to the effect that at the important special session of the House of



Delegates of the American Medical Association, held in Chicago September 16 and 17, he was chosen as chairman of one of the very important reference committees. This



HENRY A. LUCE, M.D.

is a distinct compliment to the medical profession of the state as well as to Dr. Luce.

He is a member of the rank and file of practicing physicians inasmuch as he has served his community in practice for a third of a century. All who have known Dr. Luce intimately have found him at all times courteous and obliging, never too busy to go out of his way to do a favor. As is seen, he has given his time unstintingly to organized medicine in this state. What better recognition of service performed could one receive than the highest office in the gift of those who know him best?

#### DR. CORBUS, PRESIDENT-ELECT

**D**R. BURTON R. CORBUS of Grand Rapids has been selected as president-elect of the Michigan State Medical Society. With the years of service that Dr. Corbus has rendered organized medicine in this state, little more is necessary than to enumerate those services. As Councillor from the Fifth District, Dr. Corbus has served not only Grand Rapids and Kent County physicians, he has also been Chairman of the Council up to his resignation in 1936. Following the resignation of Dr. Warnshuis, Dr. Corbus was made acting secretary of the Society, a position in which the incumbent becomes intimately acquainted with the

minute details of the organization. His experience also as chairman of the Council as well as the Executive Committee of the Council has fitted him admirably for the position which he now assumes as president-elect and which he will assume a year hence as president of the society.

Dr. Corbus was graduated from the University of Illinois in 1900, with the combined degrees of B.S. and M.D. He has practiced continuously in Grand Rapids since 1906, where he has confined his work to internal medicine. His ability in his own city has been recognized as chief of the staff of the Butterworth Hospital for five years. He was president of the Kent County Medical Society in 1912. Dr. Corbus is a fellow of the American College of Physicians and a member of the Gastroenterological Association. With the appointment of a successor as secretary of the Michigan State Medical Society in the person of Dr. L. Fernald Foster, Dr. Corbus retired from his erstwhile activities in organized medicine. Not entirely, however, for since the resignation of President Ruthven as chairman of the Joint Committee on Health Ed-



BURTON R. CORBUS, M.D.

ucation, Dr. Corbus was appointed to this position in which he is now active in the education of the public in the popularization of medical knowledge. This itself has become a very important activity of the Joint Committee, which not only includes the Michigan State Medical Society, but a score of allied organizations whose inter-

est is public and private health. Both the Michigan State Medical Society and Dr. Corbus are to be congratulated on the doctor's appointment as president-elect for 1938-39.

## DIET AND HISTORY

THE effect of diet on peoples may be sought in other quarters than physiological. So important are many articles of food that wars have been precipitated to procure or insure a supply of them; or strange institutions may grow out of the gustatory urge. The human race has always craved for sweet, hence the desire for sugar. Sugar from the Orient was known to the ancient Greeks but was used by them as medicine and was also so regarded by the Crusaders of the 13th century. The word *saccharum* as used by Pliny in his natural history, meant white, fragile and medicinal. The ancient world depended entirely on honey to sweeten its food. Bees appeared to have a monopoly in the ancient world as the producers of the means of sweetening foods. So important were bees in the production of the all necessary honey that Virgil devoted a portion of the fourth book of the *Georgics* to the subject of the rearing and culture of bees, giving specific directions as to their care. Later—much later—this monopoly was shared with sugar cane and later still with sugar beet. Sugar cane was introduced from India to Persia, thence to Egypt and to Spain, and we have it on good authority that it was introduced in the West Indies by Columbus on his second voyage. Sugar was first produced from sugar cane. Though the plant was known long before the Christian era, it did not assume much importance until after the discovery of America. The West Indies seemed peculiarly favorable for its cultivation. While the quest of gold brought the Spanish westward, sugar was a good second, and it was not long after its introduction in the West Indies until we see its cultivation by slave labor. From negro slavery on the sugar plantations of the West Indies it was only a step to the northern mainland where slave labor came to be employed in the cultivation of tobacco, rice and cotton. Out of the movement to abolish slavery on this continent resulted the Civil War and one of the great decisive battles of the world.

Long before the Battle of Gettysburg,

however, William Pitt captured the Sugar Islands and cut off from France her supply of sugar. Necessity is the mother of invention, however, and to meet the emergency, Napoleon mobilized the botanists and chemists of France and placed before them the problem of rendering their country independent of the Indies. The result of their research was a new product, the sugar beet. Eventually, the market was captured from the cane sugar industry. The early sugar beets yielded only about six per cent sugar but by plant selection and breeding, sugar beets have been produced capable of yielding fifteen to twenty per cent sugar. The first beet sugar appeared in 1812. Commercial production in the United States dates from 1869.

Thus we see sugar has become one of the most important articles of commerce which has had its influence on the fiscal policy of nations. Many of Great Britain's troubles in India have been over the production of salt. The quest for spices as a means of disguising moldy and decaying foods in the long centuries before cold storage has led to voyages of discovery all of which in turn have modified events of history.

Doubtless, sugar in a physiological sense has had its influence on the habits of nations, particularly in the way of supplying energy. It has during the past hundred years or more become one of the chief articles of diet.

## A.M.A. HOUSE OF DELEGATES DECLARES POLICY

ONE of the most momentous events in the annals of medicine was the special meeting of the House of Delegates of the American Medical Association which was held in the Palmer Hotel in Chicago on September 16. This was the third special meeting of the House of Delegates to be held in the history of the association. Approximately 175 delegates from all over the United States attended the two-day meeting. The House of Delegates, as is well known, constitutes the only body authorized to speak for the organized medical profession of the United States. The meeting was held for the purpose of drafting a policy incident upon the national health program which resulted from the deliberations of the National Health Conference which met at Washington on July 18, 19 and 20 of this year. This JOURNAL has already given the



substance of the deliberations of the National Health Conference (Page 833, September number of the JOURNAL M.S.M.S.). Three of the proposals called for the huge sum of \$850,000,000 in the interests of public and private health, half of which sum was to be provided by the Federal Government, the other half by the various states and counties.

Michigan was well represented at the special meeting of the House of Delegates with five delegates, Drs. H. A. Luce of Detroit, Claude Keyport of Grayling, Thomas Gruber of Detroit, L. G. Christian of Lansing, J. D. Brook of Granville, and B. R. Shurley representing the section on otolaryngology. In addition to these were Dr. Henry Cook, and Dr. L. Fernald Foster, president and secretary of the Michigan State Medical Society, Dr. Paul Urmston, Chairman of the council, Dr. Martin Hoffman, vice-chairman of the House of Delegates of the Michigan State Medical Society, and Dr. J. H. Dempster, editor of the JOURNAL.

The forenoon session was devoted to addresses by Dr. H. H. Shoulders of Tennessee, speaker of the House of Delegates, Dr. Irvin Abell, president of the American Medical Association, Dr. Rock Sleyster, president-elect, and Dr. Arthur H. Booth, chairman of the board of trustees. Following the addresses, numerous resolutions were presented from the floor of the House. These were referred to the appropriate committees chosen by the speaker. Members of these special committees on resolutions were chosen from wide geographical areas of the United States. After mature deliberation on the part of the various committees, their recommendations were placed before the House of Delegates as a whole with the result that the following report of the Committee to Consider the National Health Program was agreed upon.

Since it is evident that the physicians of this nation, as represented by the members of this House of Delegates convened in Special Session, favor definite and decisive action now, your Committee submits the following for your approval:

#### Recommendation I.

##### *Expansion of Public Health Service.*

1. The establishment of a federal department of health, with a secretary who shall be a doctor of medicine and a member of the President's Cabinet.

2. The general principles outlined by the technical committee for the expansion of public health and maternal and child health services are approved, and the American Medical Association definitely seeks

to cooperate in developing efficient and economical ways and means of putting into effect this recommendation.

Any expenditure made for the expansion of public health and maternal and child health services should not include the treatment of disease, except insofar as this cannot be successfully accomplished through the private practitioner.

#### Recommendation II.

##### *Expansion of Hospital Facilities.*

1. We favor the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing facilities than for additional hospitals. We heartily favor the approval of the recommendation of the technical committee pertaining to the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by payment to them of the cost of the necessary hospitalization of the medically indigent.

#### Recommendation III.

##### *Medical Care for the Medically Needy.*

1. We advocate recognition of the principle that the complete medical care of the indigent is a responsibility of the community medical and allied professions, and that such care should be organized by local government units and supported by tax funds. Since the indigent now constitute a large group in the population, we recognize that the necessity for state aid for medical care may arise in poorer communities and the federal government may need to provide funds when the state is unable to meet these emergencies. Reports of the Bureau of the Census, of the U. S. Public Health Service and of life insurance companies show that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. We wish to see continued and improved the methods and practices which have brought us to this present high plane. We wish to see established well-coordinated programs in the various states in the nation for improvement of food, housing, and the other environmental conditions which have the greatest influence on the health of our citizens. We wish also to see established a definite and far-reaching public health program for the education and information of all the people, in order that they may take advantage of the present medical service available in this country. In the days of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, providing first, that the public welfare administration procedures are simplified and coordinated; and second, that the provision of medical services is arranged by responsible, local public officials, in cooperation with the local medical profession and its allied groups. We feel that in each state a system should be developed to meet the recommendation of the National Health Conference, in conformity with its suggestion that "the rôle of the federal government should be principally that of giving financial and technical aid to states in their development of sound programs through procedures largely of their own choice."

#### Recommendation IV.

##### *General Program of Medical Care.*

We approve the principle of hospital service insurance which is being widely adopted throughout the country. It is capable of great expansion along sound lines and we particularly recommend it as a



community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that the plans should confine themselves to provision of hospital facilities and should not include any type of medical care. We recognize that health needs and means to supply needs vary throughout the United States. Studies indicate that the health needs are not identical in different localities, but that they usually depend on local conditions and therefore are primarily local problems.

We, therefore, encourage county or district medical societies, with the approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements. In addition to insurance for hospitalization, we believe it is practicable to develop cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations, to insure their soundness and financial responsibility, and have the approval of the county and state medical societies under which they operate.

We are not willing to foster any system of compulsory health insurance. We are convinced that it is a complicated bureaucratic system which has no place in a democratic state. It will undoubtedly set up a far-reaching tax system with great increase in the cost of government that would lend itself to political control and manipulation.

We recognize the soundness of the principles of workmen's compensation laws and recommend the expansion of such legislation to provide for meeting the cost of illness sustained as a result of employment in industry. We repeat our conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

#### Recommendation V.

##### *Sickness Insurance Against Loss of Wages During Sickness.*

In essence, the recommendation deals with compensation of loss of wages during sickness. We unreservedly endorse this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by qualified medical employees of the disbursing agent.

To facilitate the accomplishment of these objectives, we recommend that a committee of not more than seven physicians representative of the practicing profession, under the chairmanship of Dr. Irvin Abell, President of the American Medical Association, be appointed by the Speaker to confer and consult with the proper Federal representatives relative to the proposed National Health Program.

The above report was unanimously adopted by the House of Delegates of the American Medical Association.

Seven physicians were appointed as a body to consult with Federal authorities on the national health program. They are Dr. Irvin Abell of Louisville, Ky., president of the Medical Association; Dr. Edward H. Cary of Dallas, Texas; Dr. Walter E. Vest of Huntington, W. Va.; Dr. Walter Don-

aldson of Pittsburgh, Pa.; Dr. Fred Rankin of Lexington, Ky.; Dr. Frederick Sondern of New York City; and Dr. Henry A. Luce of Detroit, Michigan, president of the Michigan State Medical Society.

In the addresses preliminary to the petitions presented to the House of Delegates, Dr. Abell, the president of the American Medical Association, referring to the National Health Conference, drew attention to the fact that the National Health Conference did not itself come to any definite conclusions. The program of the Conference, however, was supported by representatives of the various governmental departments. He also said that many of the lay members and attendants gave unqualified endorsement to the program as a whole or in part. The representatives of the American Medical Association refrained from making suggestions, declaring that to be a function of the House of Delegates, which was the only representative body of the American Medical Association. The occasion was unique inasmuch as a vast plan for effecting health and medical care had been proposed to the people without calling the organized medical profession or any considerable representation among those engaged in practice into the conference. The forces of propaganda had evidently concluded that the American Medical Association opposed all change and that it was essentially a standpat organization. Dr. Abell felt that the time was ripe for a wider dissemination of the truth as to what had been accomplished by the American Medical Association for the people of the United States, and its true attitude towards changes that are occurring in and that are being proposed for the medical care of the people.

The American Medical Association had constantly recognized the continued expansion of preventive medicine and a wider use of medical care, he said. While this was true, the profession has at the same time been greatly concerned with the methods of administering medical care and with the ultimate effect of the various changes on the morale as well as the health of the people.

He claimed that, as a professional man, the individual physician had the right to determine the conditions of his service. Dr. Abell went on to say that hundreds of experiments in the distribution of medical care had been carried on in the past and are now



being carried on by medical societies which are component parts of the state and national organizations. The American Medical Association had never opposed the principle of group hospital insurance. It had, however, opposed the adoption of any form of state medicine, as well as the endorsement of vague plans that would make the care of the indigent and of those on the border line of indigency and those well able to pay, a burden on the taxpayer.

Dr. Rock Slevster, president-elect, referred to the well-defined propaganda financed and skillfully directed by professional promoters and carefully disguised in the name of humanitarianism. The emphasis was placed upon the alleged inadequacy of medical care with very little stress upon the fact that the great part of the population was ill-fed, ill-housed and ill-clothed. Little was said, according to Dr. Slevster, of these conditions which really created the medical problem. "The physical needs," he said, "as a contributing cause to the illness get scant attention, with the spotlight focused only on medical needs. The cart is put before the horse and unemployment is blamed to illness instead of illness to the needs created by unemployment. All of this in the face of millions in the ranks of the unemployed who are physically well, and unable to find work. The cause and effect are ignored and we are asked to concentrate on the effects and ignore the causes."

In spite of the fact, continued Dr. Slevster, that no science during the past fifty years had advanced so rapidly as medicine and that no benefits had been brought so promptly and unselfishly to the people, cleverly prepared and financed propaganda had been framed to show up medicine as backward, selfish and indifferent to the public need. The speaker went on to describe the lives of physicians whose time was given unstintingly to relief of suffering and improvement of the quality of medical care.

#### The Great Seal of Michigan

In 1835 an act was passed by the State of Michigan to provide for a seal. As familiar as we are with this seal, few can describe it accurately.

The shield in the center shows a peninsula extending into a lake, with the sun rising, and a man standing on the peninsula, a gun in his hand. Across the top of the shield is found the Latin word "Tuebor," which means, "I will defend." Underneath the shield appears the inscription "Si quæris peninsulam amœnam circumspice," which translates, "If you seek a

pleasant peninsula, look about you." Supporting the shield on either side are a moose and an elk. Over the whole, on a crest, is found the eagle of the United States, with the motto, "E pluribus unum," which means, "From many, one."

"Tuebor" has reference to the then frontier position of Michigan. Michigan was close to the British territory at the time the seal was designed and on her devolved the defense, not only of her soil, but also of the States south and east and west.

The eagle evidently symbolizes the superior authority and jurisdiction of the United States.

The motto "If you seek a pleasant peninsula, look about you," was suggested by Governor Cass and is said to be based on the mural inscription in St. Paul's Cathedral, London, commemorating its architect, Sir Christopher Wren: "If you seek his monument, look about you," referring to the cathedral itself, the product of his genius.

"E pluribus unum" is descriptive of the formation of one national state from many states.

*The House of Delegates* of the Medical Society of the State of New York, at its meeting of May 9, 1938, adopted a report of a special committee relative to the provision of medical care:

"We believe," the report stated, "that it is the function of state and local welfare authorities to provide material relief for indigents, and to certify as to the eligibility of indigents to receive medical care, but not to direct the provision of this care.

"We believe that it is then the duty of the state medical society to provide competent medical care to these certified indigents, care properly controlled and disciplined under machinery similar to the Workmen's Compensation Law provision, which has already demonstrated its ability to function satisfactorily."

(In New York State, any physician who is certified by his county medical society as qualified to render service to employees under the Workmen's Compensation Act, is authorized by law to do so on the family physician-patient basis.)

The special committee, in stating that it conceived its task to formulate a broad and fundamental policy to be followed in dealing with each problem, further stated: "It is the duty and prerogative of physicians to provide competent professional service, properly controlled and disciplined by themselves, and not by laymen, nor by government bureau or officials; it is equally the prerogative and duty of properly qualified non-medical persons or agencies to provide the facilities and financial support for this competent medical care with strict adherence to the following three fundamental problems:

1. That any plan maintains or raises the standard of quality medical care.
2. That any plan provides a fair and reasonable remuneration on an ethical basis.
3. That any plan does not involve, directly or indirectly, the interposition of a third party, as regards medical matters, between the patient and the physician of his choice."

#### Preventive Medicine

Another portion of the New York report read as follows:

"It is the opinion of the committee that the average physician is still so occupied with the problems of curative medicine that he lacks awareness of his responsibility in the field of preventive medicine. Our efforts in this direction would be materially aided if there could be developed a greater degree of coöperation on the part of public health officials generally in enlisting the participation of private practitioners in preventive medical work."

Michigan seems to be more fortunate than New York in this regard.

## President's Page

### POLITICIAN OR PARASITE

WHICH are you? Many physicians are referred to by their brother physicians as medical politicians. Webster defines a politician as one versed in or devoted to politics. Politics is defined as the art or science of government. Are you devoting sufficient of your energies toward the success of your medical organization? Organized medicine always has labored for social good. Whether you like it or not the distribution of your services, your security, your part in the social fabric is all too rapidly becoming involved in the general policies of government. Organized medicine stands for your welfare as well as the welfare of the public. You may have been a parasite formerly living off the bounty of the fruits that medical science has garnered for humanity, but if you do not become active in your organization and active in governmental affairs generally, the whole of society, as well as you yourself, will suffer.

Yours with *fortiter in re*.

A handwritten signature in cursive script, reading "Henry A. Luce".

President Michigan State Medical Society



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## THE 1938 ANNUAL SESSION

THE 73rd annual meeting of the Society at the Hotel Book-Cadillac in Detroit was the most outstanding session in the history of the Society, both from the standpoint of the record attendance as well as the excellent program presented.

That the meetings were attended by such a record number of members of the Society from all parts of the State, is evidence of the active interest Michigan physicians are taking not only in the scientific advances in medicine but also in the promotion of sound principles of medical economics.

Possibly, no other State Society can boast of a finer proportionate attendance at an annual meeting than we can in Michigan. Physicians from other states who attended the sessions this year said that the Society had the best-balanced program they ever had seen.

The two innovations on this year's programs, the Conference for Internes and Residents, and the Symposium on "The Business Side of Medicine," proved to be even more successful than had been expected. The attendance at both gave evidence that the two meetings were features that have a definite value and meet a need previously unfilled.

The committees responsible for the scientific programs are entitled to the thanks of the entire Society for their excellent work. The wide array of subjects covered and the high standing of the men who presented papers, constituted a tribute to the medical profession of Michigan. Such outstanding men are not prone to devote the time and energy necessary to prepare and present such papers unless they feel their audiences will be worthy of their efforts.

Not of the least value to the members attending the sessions was the unusually large and fine array of exhibits. A total of 76 exhibitors had booths at the convention and the time and expense they expended on their exhibits also testified to the high regard in which Michigan physicians are held. Their exhibits were an education and inspiration to everyone.

Now that the 1938 meeting has passed into history, our eyes are directed forward into 1939 and toward the goal of making next year's session even bigger and better.

## THANK YOU

YOUR Council and Officers express their sincere appreciation of the professional interest and enthusiasm as evidenced by its attendance at the Health Conference in Lansing. Over five hundred physicians, members of the State Society, attended the sessions of the conference and contributed much sound thinking and expression to its deliberations.

The momentous problems of present-day medical practice can and will be solved to the advantage of both the public and medical profession by such sustained interest as was demonstrated at the Michigan Health Conference.

## MICHIGAN SALES TAX AND PHYSICIANS

THE regulation issued effective June 1, 1938, relative to physicians, surgeons and other professional men is as follows:

"Sales of tangible personal property to persons engaged in rendering a professional service as physicians, veterinarians, architects, artists, et cetera, are sales for consumption and use incident to such service and are subject to the tax.

"When members of the various professions make sales of items, distinct and apart from the rendition of professional service, they are subject to the provisions of the Sales Tax Act."

Under this regulation the person selling to such professional men is liable for the tax on all sales of *equipment or medicine used by such persons* in the practice of their profession. Where such professional men purchase their material and equipment from some source outside the State of Michigan upon which no other sales or use tax has been paid such purchasers are then liable for the Michigan Use Tax on such purchases as they may make from without the State of Michigan.

Where such professional men in the prac-

tice of their professions also prescribe and furnish medicine to their patients they are not considered to be selling tangible personal property at retail and are therefore not required to obtain a sales tax license. However, where such professional men also maintain a retail establishment where they dispense medicine and other material to customers at retail without also at the same time furnishing them with medical service they are then construed to be making sales of tangible personal property at retail and in such case are required to obtain a sales tax license.

### Sale of Eyeglasses

With reference to the sale of eyeglasses, a new regulation becomes effective September 1st governing the sale of this material.

Effective September 1, 1938, opticians and optical supply houses will be considered to make sales at retail whether their sale is made to the ultimate customer or to an oculist or other physician. Such oculist or other physician shall be construed to be the consumer of such optical supplies as he purchases for his patients on the ground that he uses them in rendering a professional service to his patients.

However, where such oculist or other physician purchases optical supplies for his patients from outside the State of Michigan they shall then be considered to be making purchases for their own storage, use or consumption and shall be liable for the Michigan use tax as purchasers of such material. They are considered to be the users of such material in rendering a professional service.

### THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY

Oh wad some power the giftie gie us  
To see oursels as others see us!  
It wad frae monie a blunder free us  
An' foolish notion.

BURNS.

THE members of the Michigan State Medical Society have, within the past few months, received questionnaires, relating to the various departments which appear from time to time in THE JOURNAL of the Michigan State Medical Society. It is scarcely necessary to repeat that THE JOURNAL is the property of the Michigan State Medical Society, and is issued by the Council. The immediate administration of THE JOURNAL is in the hands of the Publication

Committee, appointed by the Council, which has felt that, under the editorship of James H. Dempster, M.D., Detroit, THE JOURNAL of the Michigan State Medical Society has not only maintained a high standard of quality in its scientific presentations, but has instituted a number of interesting innovations in the "Society" section of the magazine. It is the desire of the Council that THE JOURNAL meet the requirements of the members as a whole to as great an extent as possible. With this object in view, a questionnaire was issued. While the responses were not 100 per cent (no questionnaire of any description has ever been met with 100 per cent replies), still we may assume that the three hundred, more or less, represent a cross-section of the opinion of the membership of the medical society.

The most impressive result of the survey was the membership's sterling appreciation of the scientific quality of THE JOURNAL, and their general appreciation of the work of the editor.

The selection of contributed or scientific papers is almost entirely the function of the editor. "Selection" is the proper word, inasmuch as during the past decade, medical writers in this state have been so prolific that it has not been possible to include all papers submitted. Many have been returned, owing to lack of space. Only papers prepared by members of the state and county medical societies and by physicians and surgeons outside, whose papers were presented before Michigan medical audiences, have been accepted for publication, so that THE JOURNAL has been maintained distinctly a state medical journal.

The table included here is that of expressed opinion of various features of THE JOURNAL. In about half the returns, instead of expressing a preferential opinion, such as first, second, third, fourth, the readers checked off the features of THE JOURNAL which interested them from month to month. The other spaces were left blank. These checks are represented in the groups in the first column. The remainder of the table shows the departments in which preferences were expressed. For instance, sixty-four gave scientific articles first choice; four, third choice; one, fourth choice; one, the sixth; and one, the eighth.

The members were invited to make suggestions how THE JOURNAL might be improved. These are given in quotation. All



# SOCIETY ACTIVITY

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Scientific Articles.....	169	64	4	1	5	1	7	8	9	10	11	12	13	14	15	16
Editorials .....	148	8	32	8	5	3	3	5	2	3	2					
President's Page.....	112	5	11	7	4	8	6	9	4	1	3	4				
Doctor's Library.....	87	3	9	6	7	3	4	5	4	4	2	2	4	3		
Editor's Easy Chair.....	79	3	13	4	5	6	2	2	8	4	1	4	1	1		
Dept. of Society Activity.....	89	6	11	5	5	3	10	2	3	5	3	1	1	5		
Business Side of Medicine.....	130	9	11	12	5	4	5	7	2	4	1	2		2		
Medico-Legal Dept.....	110	9	6	4	8	6	4	2	7	8	2	6	1	1		
Advertisements .....	85	1	6	4	4	5	0	7	4	5	5	3	2	1	5	2
Outlines of programs of M.S.M.																
Committees .....	113	10	6	4	3	5		7	3	3	11	4	3	2		
Council & Comm. Transactions..	87	4	11	6	3	3	5	2	5	2	2	3	4	2	5	
County Society News.....	95	4	11	5	4	6	3	5	2	4	1	4	3	6	2	1
General News & Announcements.	120	8	8	9	7	2	5	3	4	2	3	4	6	2	1	
Mich. Dept. of Health Notes....	96	5	11	3	3	6	3	3	1	1	3	3	3	7	3	1
Death Notices .....	90	3	8	1		3	1	2	1	2	1	3	3	2	11	8
Do you fill out																
Sample Coupons?.....	Yes—47.	No—57.				Seldom—17.					Occasionally—18.					

are given in the language in which they were written without any attempt on the part of the committee to edit or make a selection. The publication committee is grateful to those who replied to the questionnaire. Every effort will be made to carry out the suggestions made, so far as possible.

A. S. BRUNK, M.D., *Chairman*  
Publication Committee

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## WHAT FEATURES WOULD YOU RECOMMEND FOR THE JOURNAL?

Give us articles on common problems and procedures, also have a page on what not to do in medical or surgical problems.

Good scientific articles by outstanding specialists.

Articles by leading clinicians summarizing knowledge to date concerning etiology, diagnosis and treatment of well known diseases.

Therapy, local diseases, common ailments, et cetera.

More glorifying of the private physician's office as the best and cheapest community health center.

Obtain the best scientific articles. Ivy's article is an example of the best.

I consider THE JOURNAL one of the best state journals. I have no suggestion to make. I am well satisfied.

More scientific articles of more scientific grade. Try and make the articles published of similar grade as seen in the *New England Medical and Surgical Journal*, formerly *The Boston Medical and Surgical Journal*. Try and get contributions from professors at Michigan and Wayne.

Medical histories.

Would suggest the relationship of the general practitioner to the specialist, i.e., the family physician, who encounters all sorts of problems.

There is no such thing as business side of medicine. Medicine is not a business.

Symposia.

Reports on Legal Interpretations of New Michigan Workmen's Compensation Acts.

Encourage postgraduate study and unity of organization.

Surgical and diagnostic office procedures.

THE JOURNAL is a very fine publication. No particular suggestions as to improvement.

No suggestions. You are doing a good job.

More medical economics.

Reprints of various papers read at the county society meetings.

Résumé of papers given by outstanding speakers before the various county society meetings.

Best journal that comes in.

Encouragement to younger men who are eager to

write and to see their names in print. It is a journal belonging to them, and the articles printed should not be so largely those of nationally known men for the national journals can well take care of their prolific and repetitious over-production of articles. Let the younger men know that short, stimulating articles are very acceptable at editorial headquarters and that they will be printed if they measure up to standards.

Scientific articles by out-of-state men.

One or two top-notch clinical papers, together with a larger number of short, snappy case reports.

In view of general trends, more mental hygiene and psychiatry, more book reviews.

When dosages are given in grams in medical articles, the equivalent in grains should be given in parentheses.

In the ten days following receipt of THE JOURNAL, I have read every page.

We have neglected the historical medicine. There is much to be learned from the history of medicine; it is likewise applicable to our present time. The past teaches the future. An occasional article on historical medicine would be excellent.

A very readable and worthwhile publication.

I think the "Business Side of Medicine" could be enlarged to help everyday problems.

The papers are good. THE JOURNAL is a fine paper, individually and collectively, and a fine credit to its editor.

All possible articles dealing with the keeping of "private medical practice" and discouraging socialistic and state medicine tendencies.

Articles that touch upon practice points of service in every-day practice.

Good general medical articles.

A monthly review of one or more case histories with treatment, discussion, diagnosis and pathological report similar to Cabot's cases in the *New England Medical Journal*. This could be done by some member of the University Hospital staff.

More illustrations.

Abstracts, brief ones, of recent new contributions to medicine from other journals.

A department treating of the non-medical pursuits of doctors, such as music, literature, art, etc.

"Safety on the Highways," and "The Doctor and Religion."

As high class a scientific section as possible. Curtail the remainder.

Scientific articles which are original with new thoughts and suggestions instead of rehashing of other doctors' so-called original articles.

I think it is about O.K. Might add some cases and their special handling.

Procurement of better coöperation of County Society Secretaries for better news reports.

Do something to prevent signs of "Chiropractic Physician and Surgeon."

Keep papers short. More case reports. More case reports in patients who get well. Most case reports are accompanied by an autopsy report.

Many articles read at the State Medical meeting are published too late.

I believe THE JOURNAL is an unnecessary expense. The field for the scientific articles is more than covered by the other journals which we all take; and the other items, the "Society News," et cetera, are quite superfluous.

Variety of subject matter is good, especially scientific articles. It should be remembered, however, that the greatest handicap to the general practitioner in the application of information gained in many of the articles is difficulty in carrying out concurrent laboratory examinations and check-up.

I try to read THE JOURNAL from the front to back cover each month. No preference. All good.

More on economic problems.

Scientific and medical economics.

Bigger bibliographies on authors of current articles.

More news items about what members are doing, personals. County Society reports now are dry and uninteresting to me.

Question and answer department.

Personal experience records would interest most.

It is fine as it is.

I like the entire layout of THE JOURNAL. How would a department devoted to Industrial Medicine and Surgery impress you?

Active crusade against medical competition by private groups and hospitals. Advise advertising on the idea—"Is your doctor a member of the M.S.M.S.?" The others advertise freely to our detriment.

No suggestions.

Best journal in U. S. A.

O. K. as is.

I believe the present set-up is satisfactory. Many doctors think a journal is more readable if the sheet is *not* glossy.

More scientific investigation in obstetrics. Almost every obstetrician does abortions (so-called within the law). This is not getting to the seat of the trouble, nor is it helping the race.

Do not believe it could be improved upon.

I read the entire JOURNAL from cover to cover.

More advertisers, very short articles good to older men.

More on attitude of A.M.A. on meeting problems of threatened socialized medicine.

Economics—more detailed information needed.

Essays by practicing physicians indicating how medicine may be modernized so as to improve the general health of the average individual.

Physicians' problems answered.

JOURNAL is excellent as it stands.

Have no suggestions. Just keep on making it a good medical journal.

Club and sport sections for out of town (trips in state).

Tonics (no sedatives, we have enough).

Interesting case reports with comments or discussion (viz. *British Journal of Surgery*).

Something of medical practice in other countries.

Shorter scientific articles.

Articles on common diseases, rather than rare cases.

Traumatic surgery.

Collection of papers on definite subjects, such as symposium on "Cancer" or on "Abdominal Surgery," or "Anemias," et cetera.

I think your JOURNAL has a very well rounded program. It is rather hard to list the subjects in the order of interest to me. They're all interesting.

This is one of the best journals in circulation for state use.

More of the articles should be subheaded.

Reports of investigation and prosecution of irregular and cult practice; medico-legal abstracts similar to J.A.M.A.; more on medical economics.

Under Doctor Dempster's management we have a fairly balanced diet. Personally, I have no suggestions.

Practical scientific procedures in all branches outlined in articles.

THE JOURNAL is excellently edited; no suggestions for improvement.

Every-day general problems of medicine; scientific as well as financial, et cetera.

Original articles.

In scientific articles, cut out the "textbook" history of the disease and give more practical articles on surgery and medicine. Our journal is an excellent one, but, like all things, could be improved.

A department of medical economics.

I always seem to enjoy and get the most value from a symposium type of treatment; one subject per journal treated from a number of standpoints.

Annual surveys of recent advances in small fields.

Publishing on outstanding papers as delivered before the W.C.M.S. once a month.

Diseases of winter in winter JOURNAL. Summer-time diseases in the summer.

Endocrines.

(1) Monthly magazine notice of coming important state clinics, lectures by nationally known men in county societies, University lectures, et cetera.

(2) Some local state military medical news. Army posts and Reserve Unit programs.

Stimulation of postgraduate activities. Reports of such lectures where meritorious.

Eliminate one-half scientific articles and substitute practical up-to-date papers on every-day needs of general practitioner.

Reports of progress in the sociological aspects of medicine through experiments in various parts of U. S.

Long tables of laboratory reports and experiments do not interest me. Let the specialist subscribe to magazines on his subject but let the MICHIGAN JOURNAL be simpler and appeal to the general man on later proved handling of troubles we see frequently but do not deal so very successfully with.

None. It's O.K. as is. There is no better journal published today.

I read it all. We have reason to feel very elated with the high quality of our State Medical Journal. Our editor is to be congratulated. Have no suggestions, except to advise giving him full support.

It is a good journal. Have no suggestions. We are fortunate in having such a capable editor as Dr. Dempster. He is deserving of any compliment rendered.

Appreciate work being done. Not able to offer much of any suggestions.

Would welcome summaries, both theoretical and practical (therapeutics), of various specialties.

I read only original articles of interest to myself, and announcements of coming events.

Would like to see (started in a small way) summaries of three or four outstanding articles from other current state journals, diagnostic, pathological, physiological or even a monthly case history and autopsy findings, but that could wait.

I like THE JOURNAL very much.

(1) Reports on research investigations at the two medical schools.

(2) Letters to the editor.

(3) "Then and Now" (a comparison of methods, therapeutic, diagnostic, of the past with those in vogue today).

(4) "Scientific Snacks"—one or two sentence items of readily utilizable information in place of present abstract filler.



Short abstracts of important publications and articles.

I read it from front to back cover and find it O.K. Medical ethics. Encroachments. Hospital Insurance. Group health and accident insurance for doctors.

Keep articles distributed and don't allow too many on one field.

More concrete information of the activities of the council and committees of the M.S.M.S., if possible.

Section on new advances in therapy.

Office procedures of minor surgery. For example: injection of hemorrhoids, technic and best solutions to use.

Scientific articles, first and last. Not a family magazine. Maintain the highest standard scientifically. Literature reviews, if good and new.

Articles dealing with general practice. Repeated publishing of rules, et cetera, re board of health.

Scientific articles. A brief résumé of modern therapeutics is suggested.

THE JOURNAL is good as it is.

Practical aspects of endocrine therapy, indications for endocrine therapy, products to use, et cetera.

Stick to good articles of common interest to the general practitioner.

Simple office technics with illustrations, such as Winthrop & Co., include in their house organ, and more résumés of articles as some digests offer.

Treatment of diseases as well as diagnosis.

## COUNCIL AND COMMITTEE MEETINGS

1. Thursday, July 28, 1938—Legislative Committee—WCMS Building, Detroit—6:30 p.m.

2. Wednesday, August 3, 1938—The Council—Point Lookout—11:00 a.m.

3. Sunday, August 14, 1938—Legislative Committee—Olds Hotel, Lansing—2:00 p.m.

4. Wednesday, August 31, 1938—Maternal Health Committee—Statler Hotel, Detroit—11:00 a.m.

5. Friday, September 2, 1938—Committee on Postgraduate Medical Education—WCMS Building, Detroit—12:00 noon.

6. Friday, September 9, 1938—Committee on Distribution of Medical Care—Olds Hotel, Lansing—6:00 p.m.

7. Friday, September 9, 1938—Executive Committee of the Council—Olds Hotel, Lansing—8:00 p.m.

8. Sunday, September 18, 1938—The Council—Book-Cadillac Hotel, Detroit—6:30 p.m.

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## EXECUTIVE COMMITTEE OF THE COUNCIL

August 3, 1938

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### HIGHLIGHTS:

1. Report given on "National Health Conference" and on Michigan's answer to statement made by U. S. Assistant Attorney General.
2. "Physicians and Cultists"—the ruling of the A.M.A. Judicial Council reaffirmed.
3. Referred to the M.S.M.S. House of Delegates:
  - (a) Merger of Delta and Schoolcraft County Medical Societies.
  - (b) Elimination of present 13th Councilor District.
  - (c) Change in Constitution re membership.
  - (d) Results of survey on distribution of medical care (green questionnaire) reported.
4. Annual Report of The Council approved.
5. Postgraduate Convocation arranged for 1938 Annual Meeting, Detroit.
6. Michigan Attorney General requests article on "Evils of Marihuana."

1. *Roll Call*.—The meeting was called to order by P. R. Urmston, Chairman, at Point Lookout, the summer home of Drs. Urmston and Foster, at 10:00 a.m. All councilors and officers were present, except Drs. W. A. Manthei and Geo. A. Sherman. Others present: Drs. T. K. Gruber, F. E. Reeder, R. H. Pino, L. G. Christian, and Mr. J. A. Bechtel.

2. *Minutes*.—The minutes of the meeting of June 13 were read and approved.

3. *Financial Report*.—Bills payable for the month were presented, and ordered paid, motion of Drs. Greene-Cummings. Carried. The financial report for July was presented, studied, and approved; also the report of actual expenditures vs. the budget was analyzed. The report on bonds was presented by Treasurer Hyland, who stated that the bonds were gradually going up, having appreciated \$1,200 in recent months. Upon recommendation of Treasurer Hyland, motion was made by Dr. Carstens and seconded by several that the bonds committee be granted permission to dispose of bonds which they recommend be sold, in exchange for AAA bonds, at the best time, as decided by this committee. Carried unanimously. The Bond Committee was thanked for this report and good work.

4. *Annual Report of the Council*.—This proposed report was read in its entirety, and adopted as a

whole, on motion of Dr. Andrews seconded by several and carried unanimously.

5. *Merger of Delta and Schoolcraft County Medical Societies*.—The request of these two county medical societies to be merged was presented. Motion of Drs. Andrews-McIntyre that the merger be recommended to the House of Delegates. Carried unanimously.

6. *13th Councilor District*.—The request of the Alpena County Medical Society to be annexed to the 10th District, and the request of the Northern Michigan Medical Society to be annexed to the 9th Councilor District, thus eliminating the present 13th Councilor District, was presented and explained by Councilor Van Leuven, who urged the change. Motion of Drs. Riley-McIntyre that the proposed changes be recommended to the House of Delegates. Carried unanimously.

Motion was made by Dr. McIntyre and seconded by several that a recommendation be made to the House of Delegates that the present 17th Councilor District in the Upper Peninsula be re-numbered to "13th Councilor District." Carried unanimously.

7. *Report of Special Committee on Medico-Legal Activity*.—Dr. Greene reported for the committee, and presented the recommendations which had been considered by the Executive Committee on June 30th.

After full discussion, motion of Drs. Holmes-Bandy that the recommendations of the committee be adopted. Carried unanimously.

8. *Proposed Constitutional Change.*—Dr. Greene reported for his committee, recommending a change in Article 3 Section 1 of the Constitution, to insure that active membership in the county medical society shall include active membership in the State Society, by adding to the present section the words "Membership in a county medical society on a basis not including membership in the Michigan State Medical Society is not recognized." Motion of Drs. Greene-Holmes that the Council recommend to the House of Delegates the proposed change in the constitution. Carried unanimously.

9. *Legislative Committee Report.*—Dr. Christian presented this report, which was approved.

10. *Physicians and Cultists.*—The decision of the A.M.A. at its 1938 meeting re "Physicians and Cultists" (part of the report of the Judicial Council) was mentioned, and ordered placed in the Secretary's Letter and in the M.S.M.S. JOURNAL.

11. *Iodized Salt Committee.*—The report of the committee was read, and discussed. Motion of Drs. Carstens-Cummings that the M.S.M.S. pay the Iodized Salt Committee's bill of \$286.00. Carried unanimously.

12. *Asst. Attorney General's Statement.*—Dr. Luce reported for President Cook re the action of the M.S.M.S. officers in answering this attack. Motion of Drs. Holmes-Heavenrich that the Council approve the newspaper releases and authorize the President, Secretary and Chairman of the Council to make further plans and releases as needed. Carried unanimously.

13. *National Health Conference.*—Dr. Luce presented Dr. Cook's report, and analysis of the National Health Conference. The report was received and placed on file.

14. *Group Hospitalization.*—A report was presented by Dr. Gruber, Chairman of the Liaison Committee. Reference was made to the A.M.A. Resolution covering anesthetists, roentgenologists and pathologists. Motion of Dr. Cummings seconded by several that the Committee report be accepted. Carried unanimously.

15. *Distribution of Medical Care.*—Dr. Pino, Chairman of the Committee, gave a report on re-

turns from the 1,119 green questionnaires. He read a supplement to the Annual Report of his committee, and discussed the survey in detail. Motion of Dr. McIntyre seconded by several that the report of the Committee on the questionnaire be received and referred to the House of Delegates. Carried unanimously.

Motion of Drs. Haughey-Riley that the expenses of compiling the reports, in the total sum of \$200.00, be paid. Motion carried (Dr. Holmes dissenting).

16. *A.M.A. Survey.*—Secretary Foster gave a progress report on this activity.

17. *Postgraduate Medical Education.*—The Secretary outlined the requirements for p.g. certificates on the occasion of the annual meeting of 1938. This was thoroughly discussed.

18. (a) *Article on the "Evils of Marihuana."*—The request of the Michigan Attorney General, thru the State Board of Registration in Medicine, for a brief article on this subject, was mentioned. The Secretary stated that help is being given to the Attorney General.

(b) The Executive Secretary reported on the distribution of the \$1.00 state Narcotic Tax, as reported by the Department of Drugs and Drugstores.

(c) The Secretary of the State Board of Registration in Medicine presented a letter proposed to be written to the Michigan Attorney General re the practice of medicine by corporations.

19. *Afflicted Children.*—(a) A letter from the Crippled Children Commission re private agreements between doctors and patients in afflicted child cases was read. Motion of Drs. Cummings-Holmes that this matter be referred to the Probate Judges' Association, as the Probate Judges have the authority in such matters. Carried unanimously.

(b) A letter from the Crippled Children Commission regarding a situation in Monroe County was read. The matter involved free choice of physicians. Motion of Dr. Cummings seconded by several that the Council approves the sentiment of Dr. Wayne S. Ramsey, Executive Secretary of the Commission. Carried unanimously.

20. *Adjournment.*—The meeting was adjourned at 6:15 p.m. A rising vote of thanks was given to Dr. and Mrs. Urmston and Dr. and Mrs. Foster for their wonderful hospitality on this occasion.

#### PROS AND CONS ON REFERENDUM OF NOVEMBER 8 OF WELFARE LAWS OF 1937

##### *Those Who Would Have the Laws Defeated Hold:*

1. That the 1937 Welfare Laws mean state and federal domination. To get best results, counties should be left alone to solve welfare problems.
2. That local administration will result in the saving of money. Local administrators know the people and can handle relief in a thrifty fashion.
3. That some Probate Judges claim they can handle Mothers' Pensions in a more humane and kindly fashion.

##### *Those Who Would Have the Laws Approved Hold:*

1. That their defeat will result in a loss of money given by the United States to the State of Michigan for Mothers' Pensions and Blind Relief, amounting to several million dollars annually.
2. That approval of the 1937 Welfare Laws would lead to a reduction of the gigantic dependency load, by rehabilitation and non-political administration.
3. That approval of the 1937 Welfare Laws would mean economy by elimination of duplication of services.
4. That the state which is producing more than one-half of the money for welfare services has the right to some voice in administration. (The local county commission of three would have two appointed by the County Supervisors and one appointed by the State.)

United States laws offering state welfare subsidies ask for honest and efficient local administration and humane treatment of clients.

In 1937, under the old plan, the E.R.A. paid only \$681,000 to physicians in Michigan for medical care. The 1937 Welfare laws specifically provide for medical care for the relief client, and establish what shall be the physician-patient relationship.

(From notes made at Wm. J. Norton's address before Oakland County Medical Society on July 13, 1938.)



## MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

### SHIGA DYSENTERY OUTBREAK

The need for a state-wide rural sanitation program has been forcefully brought to public attention by the recent outbreak of Shiga dysentery at Owosso with its attendant publicity. Such was the consensus of the conference of epidemiologists and laboratorians meeting with the State Health Commissioner at Lansing, August 23.

Dysentery ranging from the mild to more virulent types has been reported with increasing frequency in the rural and resort areas of Michigan during the past few years. The virulence of the Shiga outbreak in the Owosso area has brought to the fore the urgent need for extensive efforts to control the causes of all types of dysentery, the conference reported.

More than 150 cases of diarrhea occurring in and around Owosso have been carefully studied by the State Health Department. Thirty of these cases have been diagnosed as probably Shiga dysentery. Seven deaths have occurred in the Owosso outbreak and three others have been reported elsewhere. The disease has made its appearance in Bay County and suspected cases have been reported in other northern counties.

The manner of spread in practically all cases studied indicates poor community sanitation and poor personal hygiene, the conference reported. The Shiga cases have not been shown to have been spread by food, water or milk, although all of these modes are possible. Many cases have indicated no possibility of direct contact, thus adding weight to poor sanitation as a possible source.

Most of the reported cases have occurred in families of the lower economic status. Such families, the conference announced, have in many cases poor toilet facilities, poor food storage, little or no protection from flies by screening, unsatisfactory water supplies, inadequate provision for hand washing, and insanitary sleeping and living conditions.

Great or rapid spread of the virulent dysenteries is not likely in the immediate future, according to the conference report. Present programs will keep the disease in abeyance until cold weather. The threat of dysentery and related diseases, however, will continue in Michigan with increasing prevalence each summer unless marked, continued and well-organized improvement is brought about in small town and rural sanitation.

The state-wide rural sanitation program outlined by the conference includes the following measures:

- a. Excreta disposal.
  1. Sewer connections for all homes when such are available.
  2. Where outdoor toilets are necessary, they must be deep, clean, fly-proof and properly located so as not to contaminate a water supply.
  3. All existing improper outdoor toilets to be cleaned at once and contents chemically treated.
- b. Proper water supply.
  1. Use of approved municipal supplies when available.
  2. Systematic testing of wells to determine location of dangerous supplies.
  3. Elimination of unsafe wells.
- c. Pasteurization of all milk.

- d. Sanitary handling of all food supplies.
- e. Screening of all dwellings.
- f. Cleaning up of all fly breeding places.
- g. Improvement of general sanitation.
- h. Education of public in how to live and use proper sanitary facilities.

There is no one simple procedure which may be followed in such a proposed rural sanitation program. It is rather a continued, concerted effort throughout the state which is needed if the present serious rural sanitation problem is to be solved. The conference recommended the organization of strong, well-financed local health departments in every Michigan county as the starting point for a real attack upon the causes of dysentery in the rural areas.

### ANTISYPHILITIC DRUGS AND LABORATORY SERVICE FREE

Drugs for the treatment of syphilis have been distributed free to physicians by the Michigan Department of Health since January of this year. During the first six months of this service a total of 36,897 doses of mapharsen, 25,195 doses of neoarsphenamine and 87,150 doses of bismuth subsalicylate in oil have been sent to physicians upon request for medically indigent patients.

A marked increase in the number of cases of syphilis reported also occurred during this period. There were 7,567 cases reported compared with 3,961 during the first six months of 1937.

Starting with the new fiscal year on July 1, antisyphilitic drugs have been distributed to physicians for all patients regardless of indigency. Any physician may obtain these drugs free from his local full-time health department. In counties where there is no such department, drugs may be obtained upon request directly from the Michigan Department of Health at Lansing. Case reports are required as usual under the rules and regulations of the Department.

Laboratory service for the serodiagnosis of syphilis, previously provided only for medically indigent cases, is now also on a free basis. This service may be obtained by physicians from the Lansing, Grand Rapids or Houghton laboratories of the Michigan Department of Health and from most large municipal laboratories. A new branch laboratory is being established at Powers in the Upper Peninsula to serve the physicians in that area. The Department has granted subsidies to several municipal laboratories to aid them in expanding their serologic service.

The Bureau of Laboratories has recently strengthened its dark field examination service to aid physicians in securing the earliest possible diagnosis of syphilis. Special outfits for taking specimens of early syphilitic lesions for the dark field examination have been made available and may be obtained by physicians upon request to the Michigan Department of Health. The outfits will also be available through local full-time health departments. The dark field examinations will be made at the Grand Rapids and Houghton branch laboratories as well as at the central laboratories at Lansing.

### HEALTH RECORD FOR THE FIRST SIX MONTHS OF 1938

The health record for Michigan during the first six months of 1938 is one of the most favorable in recent years, according to records compiled by the Bureau of Records and Statistics. While the total mortality from all causes was declining ten



per cent, births were increasing almost four per cent over comparative reports for the first six months of 1937.

There were 2,798 fewer deaths in 1938 than in the same period of 1937, a trend which if maintained throughout the year will set a new low annual mortality rate. A total of 25,652 deaths was reported this year compared with 28,450 in the first half of 1937. This declining trend is not limited to any one cause nor to a single month, but becomes more pronounced throughout each succeeding month of the year.

Births, too, show an encouraging trend throughout the early months of 1938, indicating that the rising birth rate Michigan has experienced since 1933 will be continued this year. There were 1,675 more births in the first six months of 1938 than the total of 44,534 which occurred in the same period of last year.

Infant deaths decreased from 2,363 to 2,076 during the first six months of this year. If this decline continues, there is every indication that the 1938 infant mortality rate will set an all-time low record.

Deaths of mothers from causes associated with childbirth show a slight decrease from 166 to 161. In view of the surprisingly low maternal mortality rate of 3.56 established last year, even a slight decline is encouraging.

The decrease in mortality during these first six months cannot be attributed to any one cause, for decreases are noted in tuberculosis, diphtheria, pneumonia, nephritis, automobile accidents, homicides and accidents exclusive of automobile.

Probably the greatest single decrease in mortality occurred in pneumonia. Deaths from this cause declined more than one-third. There were 1,688 deaths from pneumonia during the first six months of this year compared with 2,703 in 1937. Mortality from respiratory diseases of all types declined greatly during the mild winter of last year.

Deaths caused by automobile accidents also decreased greatly during this period. Total deaths from this cause dropped from 944 in 1937 to 560 this year. Although the great majority of automobile deaths occur during the latter months of the year, it is almost certain that the mortality this year will not approach the all-time high record established in 1937.

Nephritis deaths during the first six months totaled 1,410 compared to 1,593 last year. Diphtheria deaths dropped from 26 to 19. Tuberculosis mortality, which has been practically stationary during the past two years, again started to decline during the early months of 1938. There were 984 deaths compared with 1,126 last year. Homicides dropped from 91 to 67.

Higher mortality was experienced in heart disease, cancer, apoplexy, diabetes, typhoid fever, diarrhea and enteritis, and suicides.

Deaths from heart disease increased from 5,244 to 5,324 this year. Cancer deaths, after a slight decline last year, again increased slightly from 2,777 to 2,819 during the comparative six months' period. Diabetes deaths increased slightly from 650 to 668. There were 13 typhoid deaths compared with 10 last year. Diarrhea and enteritis deaths totaled 104, an increase of nine over 1937. Suicides increased from 352 to 355.

## STATE HEALTH CONFERENCE

A significant conference on health and medical care sponsored by Governor Frank Murphy's Study Committee on Social Welfare Relationships was held September 10 at East Lansing. The conference program was devoted to a discussion of ways in which the government can assist people to obtain through



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the practicing physicians a greater distribution of medical care. Approximately 800 representatives of the State Medical Society, consumers' groups and governmental agencies were in attendance.

The morning program included a preliminary report of the Governor's committee on the medical needs of governmental relief clients by Dr. Don W. Gudakunst, State Health Commissioner. Dr. L. Fernald Foster, secretary of the Michigan State Medical Society, discussed the American Medical Association survey of medical care in Michigan. The economic factors of medical care were presented by William J. Norton, chairman of the State Welfare Commission.

Dr. C. E. Waller, assistant surgeon general of the U. S. Public Health Service, outlined the national health program. At the luncheon session Governor Murphy presented his future health plans for Michigan.

Three sectional meetings were held in the afternoon based upon the general topics of expansion of health services, medical care for the indigent, and health insurance. Speakers included Dr. Henry Cook, president of the Michigan State Medical Society; Dr. Henry F. Vaughan, Detroit Commissioner of Health; Howard Hunter, regional director of the Works Progress Administration; Dr. Sarah S. Dietrick, field consultant for the Federal Children's Bureau; Dr. Thomas K. Gruber, superintendent of Eloise State Hospital; Dr. R. G. Tuck, director of the Oakland County E.R.A.; Dr. Ralph Pino, chairman of the committee on distribution of medical care of the Michigan State Medical Society; and Albert E. Meder of Detroit. Dr. Henry Luce, president-elect of the Michigan State Medical Society, presided over the summarizing session of the conference in the afternoon.

The conference provided an opportunity for all parties concerned with medical care to come together for a discussion of their mutual problems. Representatives of organized medicine, governmental agencies immediately concerned, and consumers' groups took an active part in the discussions.

It is especially significant that the conference voted to continue its activities by appointing standing committees to carry on studies of the problems developing out of the conference. At the summarizing session, the conference approved resolutions for the appointment of committees (1) to study the need for expansion of health services including the provision of additional laboratories and diagnostic health centers; (2) to consider problems involved in distribution of medical care to the needy; and (3) to study the various hospital and health insurance plans and industrial health problems.

Members of the committees will include representatives of the State Medical Society, consumers' groups and governmental agencies concerned. The committees will report their studies and plans to the Study Committee on Social Welfare Relationships which sponsored the conference.

## PERSONNEL

Dr. Russell E. Pleune, who has been in charge of venereal disease control activities of the Michigan Department of Health, has been appointed director of the Houghton-Keweenaw District Health Department and will assume his new position October 1.

Dr. C. E. Merritt, former director of the Dickinson County Health Department, has accepted a new position as director of the Bay County Health Department.

Dr. R. J. Harrington of Muskegon has been appointed director of the Muskegon County Health Department and has assumed his new duties.

Dr. C. C. Corkill, former director of the Ontonagon-Baraga Health District, has resigned to accept a new position as director of the Meneminee County Health Department, where he succeeds Dr. L. A. Berg.

Dr. Ray S. Dixon of Detroit has accepted a position as part-time consultant in venereal disease control with the Michigan Department of Health. Dr. Eugene S. Browning of Grand Rapids has also accepted a position with the Department to conduct syphilis control work.

Two other recent additions to the Department staff include Dr. Raymond W. Maurer and Dr. Norman V. DeNosquo, both of Detroit, who have been attached to the staff of the Bureau of Epidemiology.

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## ◆ General News and Announcements ◆

*The Jackson Clinic* of Jackson announces the addition to its medical staff of Dr. Grant Otis and Dr. Walter R. Finton.

\* \* \*

*The American Medical Association's* Annual Session of 1939 will be held in St. Louis, Missouri, May 15 to 19.

\* \* \*

*A fateful day* for the medical profession of Michigan and the United States: November 8, 1938, General Election.

\* \* \*

*The Conference on Rural Medicine* was held at the Mary Imogene Bassett Hospital of Cooperstown, N. Y., on October 7 and 8, 1938.

\* \* \*

*A physician's used equipment and supplies*, located in Lansing, are available. For details write Box R, 2020 Old Tower, Lansing, c/o Michigan State Medical Society.

\* \* \*

*An article* entitled "An Outbreak of Jaundice in Detroit" by J. G. Molner, M.D., and J. A. Kasper, M.D., both of Detroit, appeared in the *Journal of the A.M.A.*, June 18, 1938.

\* \* \*

*Dr. Wm. Hyland* of Grand Rapids and *Dr. Ira Downer* of Detroit were elected respectively chairman and secretary of the surgical section of the Michigan State Medical Society.

\* \* \*

*Drs. H. H. Cummings, M. M. Peet* of Ann Arbor, and *C. P. McCord* of Detroit, were guest speakers on the annual program of the State Medical Society of Wisconsin. The meeting was held in Milwaukee, September 14, 15, 16.

\* \* \*

*The Houghton-Baraga-Keweenaw County Medical Society* has just published its constitution and by-laws in a handsome little volume of 48 pages. Included within the copper-colored covers are the Principles of Medical Ethics.

\* \* \*

*Dr. Stephen Fairbanks*, formerly in private practice at Luther, Michigan, has become Camp Surgeon and Commanding Officer of the Station Hospital at Camp Custer. He performs his duties as Captain in the Medical Reserve Corps, United States Army.

\* \* \*

*Mead Johnson & Co., of Evansville, Indiana*, courteously relinquished the front page of the September issue of the JOURNAL in order that the "Convention Number" could be featured by a special cover design. Thanks to Mead Johnson & Co. are extended by the Publication Committee of the JOURNAL.

\* \* \*

*The New York Academy of Medicine* will hold its Eleventh Annual Graduate Fortnight October 21 to November 4, 1938. The subject of this year's Fortnight is "Diseases of the Blood and Blood-forming Organs." For program write the Academy at 2 East 103rd St., New York City.

*The Idaho State Medical Society* annual meeting program featured an all-Michigan "cast." The convention was held at Sun Valley, Idaho, September 6 to 10. Speakers were A. C. Furstenberg, M.D., C. C. Sturgis, M.D., F. A. Collier, M.D., Norman Miller, M.D., and H. B. Lewis, Ph.D., of Ann Arbor, and Wm. J. Burns of Lansing.

\* \* \*

*The Eaton County Medical Society* inaugurated its 1938-39 activities with a "get-together dinner" with members of the Board of Supervisors, at the Carnes Tavern, Charlotte, September 15. This fostering of a spirit of coöperation and friendliness between county medical societies and Boards of Supervisors is worthy of emulation in all parts of the state, and the country. Congratulations, Eaton County Medical Society.

\* \* \*

*Wall Chemicals, Inc.*, of 1059-65 W. Grand Boulevard, Detroit, exhibited at the annual meeting of the Michigan State Medical Society in Detroit in September, despite the unfortunate explosion it experienced at its plant on August 27. The producing equipment was intact, and the organization was running smoothly in ten days' time. Congratulations on this pluck, and best wishes for success in the future.

\* \* \*

*All who practice Medicine* must be registered and licensed: The Attorney General's office has ruled (according to the Michigan State Board of Registration in Medicine) that under Act 237, Public Acts of 1899, and acts amendatory thereto, any and all who practice medicine either within or without a hospital must be registered and licensed to practice medicine in Michigan with the exception of twelve months' rotating internship, which is an educational requirement and which this Board is authorized by law to fix.

\* \* \*

*Mr. Lawrence Salter*, who for a number of years has been on the *Detroit Free Press* staff, has accepted a position in the publicity department of the American Medical Association in Chicago. Mr. Salter has been long and favorably known to the profession of the state, where he has been a constant attendant at the various medical conventions. The doctors have always found him a sympathetic and intelligent reporter of medical news. The best wishes of his many friends are extended to him in his wider field of usefulness.

\* \* \*

*Alexander Hamilton's* wisdom is exemplified by the following lines, so fitting in present day America: "To balance a large state of society . . . is a work of so great difficulty, that no human genius, however comprehensive, is able, by the mere dint of reason and reflection, to effect it. The judgments of many must unite in the work: experience must guide their labor; time must bring it to perfection, and the feeling of inconveniences must correct the mistakes which they inevitably fall into in their first trials and experiments."

In other words, Government, when participating in any planning, must do its planning in coöperation *with* rather than for Business, or Labor, or Medicine. Without this coöperative relationship, the planning is doomed for failure.



*Crippled and Afflicted Child Commitments*, for August, 1938:

Crippled Child: Total cases, 518, of which 173 went to University Hospital; 345 to miscellaneous hospitals. From Wayne County, of the above, 8 went to University Hospital; 60 to miscellaneous hospitals; total 68.

Afflicted Child: Total cases, 2,718, of which 302 went to University Hospital; 2,416 went to miscellaneous hospitals. From Wayne County, of the above, 42 went to University Hospital; 538 went to miscellaneous hospitals; total 680.

\* \* \*

A "State Society Night" was celebrated by the Berrien-Cass County Medical Society at the Berrien Country Club on Wednesday, August 31. The program included a discussion of the "Michigan Health Conference" by P. R. Urmston, M.D., of Bay City, Council Chairman of the M.S.M.S.; a discussion of the "National Health Conference" by President Henry Cook, M.D., of Flint. "Group Hospitalization" was discussed by Mac F. Cahal of Chicago, Secretary of the National Radiological Association.

L. Fernald Foster, M.D., Bay City, Secretary of the M.S.M.S., spoke on the "Opportunity for Leadership by the County Medical Society." The Executive Secretary, Wm. J. Burns of Lansing, discussed "The Benefits of Unified Action."

Other state officers present were Vernor M. Moore, M.D., of Grand Rapids; Wilfrid Haughey, M.D., of Battle Creek; F. T. Andrews, M.D., of Kalamazoo; Roy H. Holmes, M.D., of Muskegon; and H. H. Cummings, M.D., of Ann Arbor.

The meeting was attended by approximately 150 physicians and their wives and guests.

The Mayo Clinic wishes to complete its set of the JOURNAL of the Michigan State Medical Society and is in need of the following numbers of early volumes:

Vol. 1 to 3: 1902-04 inclusive

9: 1910—1 to 9

16: 1917—3

17: 1918—8-9-12

18: 1919—1 to 11

19: 1920—1-2

21: 1922—10 to 12

22: 1923—1 to 7, 10 to 12

24: 1925—1.

If any members can supply these numbers, and are willing to contribute same to the Mayo Clinic, they are requested to write direct to Frida Pliefke, Librarian, Mayo Clinic, Rochester, Minn.

\* \* \*

*Because liver was administered* as a part of the diet when first introduced as a means of treating pernicious anemia it was natural that the potency of the first liver extracts should be expressed in terms of ingested whole liver. In spite of the inaccuracies of this method there was no other standard until the recent establishment of the official U.S. P. unit. The unit is that amount of liver which, when given daily to patients with Addisonian pernicious anemia, will produce a hematopoietic response which is acceptable to the U.S.P. Anti-Anemia Preparations Advisory Board.

For several years the liver extracts prepared by Eli Lilly and Company have been standardized on patients with Addisonian pernicious anemia in relapse and the accuracy of the method has now been attested by the official acceptance of Liver Extracts-Lilly, Solution Liver Extract-Lilly, and Solution Liver Extract Concentrated-Lilly.

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**American Board of Obstetrics and Gynecology, Inc., Examinations**

The next examinations (written and review of case histories) for Group B candidates will be held in various cities of the United States and Canada on Saturday, November 5, 1938, at 2:00 P.M., and on Saturday, February 4, 1939. Application for admission to the written examination scheduled for February 4, 1939, must be filed on an official application form in the office of the Secretary at least sixty days prior to this date (or before December 4, 1938).

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in St. Louis, Missouri, immediately prior to the annual meeting of the American Medical Association in May, 1939. Application for admission Group A examinations must be on file in the Secretary's Office before April 1, 1939.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Bldg., Pittsburgh (6), Pa.

\* \* \*

For the first time in the seventeen years of its existence, Michigan's Annual Public Health Conference will convene this year in a city other than Lansing. It will meet in Grand Rapids, in the Civic Auditorium, on November 9, 10 and 11, 1938.

Starting in 1921 as an informal meeting of health officers and public health nurses with the staff of the Michigan Department of Health, the conference has grown to be one of the largest gatherings of its kind in the country. It draws members of all the health

professions and interested laymen from every section of the state. Last year there was a registered attendance of a little more than 1,200 health officers, practicing physicians, dentists, public health nurses, laboratorians, sanitary officers and lay leaders from all but two of Michigan's 83 counties.

Program plans for the November meeting in Grand Rapids include discussions of the following major topics:

The Shiga Dysentery Outbreak  
The Role of Sanitation in Disease Prevention  
Rabies  
Syphilis Control  
Mental Hygiene  
Pneumonia Control  
Trends and Changes in Public Health Administration  
Michigan's Cancer Control Program  
The Nurse in the Program of Maternal and Child Health

A number of other topics are still tentative, or those invited to discuss them have not definitely accepted. It is hoped that the final program will be available from the office of the State Commissioner of Health within a short time. Physicians in the area around Grand Rapids will receive the program with a special invitation to attend any of the sessions of the conference, and others interested will be equally welcome.

\* \* \*

**State Health Conference**

In spite of the short notice to the medical profession, over four hundred doctors attended the state health conference at Lansing on September 10th. This meeting was sponsored by the Study Committee on Social Welfare Relationships. Since this meeting was reported in substance in many of the daily papers throughout the state the proceed-

**INTERNATIONAL MEDICAL ASSEMBLY**

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OCTOBER 31, NOVEMBER 1, 2, 3, 4, 1938

Pre-assembly clinics, October 29; Post-assembly clinics, November 5, Philadelphia hospitals

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Walter C. Alvarez, Rochester, Minn.  
Wayne Babcock, Philadelphia, Pa.  
Claude S. Beck, Cleveland, Ohio  
George Blumer, New Haven, Conn.  
Peter T. Bohan, Kansas City, Mo.  
William F. Braasch, Rochester, Minn.  
Richard B. Cattell, Boston, Mass.  
Henry A. Christian, Boston, Mass.  
Arthur C. Christie, Washington, D. C.  
Edward D. Churchill, Boston, Mass.  
Dr. Louis H. Clerf, Philadelphia, Pa.  
W. McK. Craig, Rochester, Minn.  
George W. Crile, Cleveland, Ohio  
John S. Coulter, Chicago, Ill.  
Elliott C. Cutler, Boston, Mass.  
Walter E. Dandy, Baltimore, Md.  
William Darrach, New York, N. Y.  
Vernon C. David, Chicago, Ill.  
Loyal Davis, Chicago, Ill.  
Robert S. Dinsmore, Cleveland, Ohio  
Claude F. Dixon, Rochester, Minn.  
Nicholson J. Eastman, Baltimore, Md.  
Edmond M. Eberts, Montreal, Canada  
E. L. Eliason, Philadelphia, Pa.  
Charles A. Elliott, Chicago, Ill.  
John F. Erdmann, New York, N. Y.  
Clarence B. Farrar, Toronto, Canada  
John R. Fraser, Montreal, Canada  
John C. Gittings, Philadelphia, Pa.  
Russell L. Haden, Cleveland, Ohio

William D. Haggard, Nashville, Tenn.  
George A. Harrop, New York, N. Y.  
Charles G. Heyd, New York, N. Y.  
Fred J. Hodges, Ann Arbor, Mich.  
Chevalier Jackson, Philadelphia, Pa.  
Chevalier L. Jackson, Philadelphia, Pa.  
Elliott P. Joslin, Boston, Mass.  
Frederick J. Kalteyer, Philadelphia, Pa.  
Floyd E. Keene, Philadelphia, Pa.  
Herman L. Kretschmer, Chicago, Ill.  
Frank Lahey, Boston, Mass.  
Dean Lewis, Baltimore, Md.  
Walter I. Lillie, Philadelphia, Pa.  
Perrin H. Long, Baltimore, Md.  
Warfield T. Longcope, Baltimore, Md.  
William E. Lower, Cleveland, Ohio.  
Charles W. Mayo, Rochester, Minn.  
Irvine McQuarrie, Minneapolis, Minn.  
James H. Means, Boston, Mass.  
Arthur R. Metz, Chicago, Ill.  
William S. Middleton, Madison, Wis.  
John J. Moorhead, New York, N. Y.  
George P. Muller, Philadelphia, Pa.  
Clay Ray Murray, New York, N. Y.  
John H. Musser, New Orleans, La.  
Howard C. Naffziger, San Francisco, Cal.  
Frank R. Ober, Boston, Mass.  
Eric Oldberg, Chicago, Ill.  
Oliver S. Ormsby, Chicago, Ill.  
Hubley R. Owen, Philadelphia, Pa.  
Wilder Penfield, Montreal, Canada

George E. Pfahler, Philadelphia, Pa.  
Fred W. Rankin, Lexington, Ky.  
Robert F. Ridpath, Philadelphia, Pa.  
David Riesman, Philadelphia, Pa.  
Leonard G. Rowntree, Philadelphia, Pa.  
Thomas H. Russell, New York, N. Y.  
E. Kost Shelton, Los Angeles, Cal.  
Fred M. Smith, Iowa City, Iowa  
Marius N. Smith-Petersen, Boston, Mass.  
Alfred Stengel, Philadelphia, Pa.  
Charles Stockard, New York, N. Y.  
Cyrus C. Sturgis, Ann Arbor, Mich.  
Robert G. Torrey, Philadelphia, Pa.  
William G. Turner, Montreal, Canada  
Professor von Eicken, Berlin, Germany  
Waltman Walters, Rochester, Minn.  
G. Harlan Wells, Philadelphia, Pa.  
Allen O. Whipple, New York, N. Y.  
Paul D. White, Boston, Mass.  
Hugh H. Young, Baltimore, Md.

**TENTATIVE FOREIGN ACCEPTANCES:**

Rt. Hon. Lord Horder, London, England  
Mr. A. Lawrence Abel, F.R.C.S., London, England  
Sir John Fraser, Edinburgh, Scotland  
Professor Mario Donati, Milan, Italy  
Professor Roberto Alessandri, Rome, Italy  
Professor Ferdinand Sauerbruch, Berlin, Germany

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ings will not be news when the JOURNAL of the Michigan State Medical Society reaches its readers. Keen interest, however, was shown by all present in the various subjects discussed. Among the principal speakers were Governor Murphy and William J. Norton, Chairman of the State's Emergency Relief Administration. Mr. Norton went on to say that the economic pressure made changes in medical care inevitable. It was agreed that every person, regardless of his economic and social position, was entitled to the best quality of medical service. Governor Murphy mentioned that whatever was done must be accomplished without hampering the physician in the actual administration of medical care to his patients. Mr. Norton claimed that some sort of insurance plan should be best for both doctors and indigent patients inasmuch as it would preserve the patient's self-respect and at the same time afford the physician remuneration for his services. An important matter which was discussed was the lack of clinical and other laboratory facilities in the more sparsely settled portions of the state and a movement was favored to provide adequate laboratory service throughout the northern portion of the state where it was urgently needed. Those present who took part in the program were as follows: Governor Frank Murphy; William J. Norton, Chairman of the State Welfare Commission; Don W. Gudakunst, M.D., Commissioner of the Michigan Department of Health; L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society; C. E. Waller, M.D., Assistant Surgeon General, U. S. Public Health Service; Robert B. Harkness, M.D., Secretary, State Council of Health; Henry F. Vaughan, D.P.H., Commissioner of the Detroit Department of Health; Howard Hunter, Regional Director of the Works Progress Administration; Fred

R. Johnson, General Secretary, Michigan Children's Aid Society; R. G. Tuck, M.D., Director, Oakland County E.R.A.; Ralph Pino, M.D., Chairman, Distribution of Medical Care Committee, State Medical Society; Sarah S. Dietrick, M.D., Field Consultant, Federal Children's Bureau; Thomas K. Gruber, M.D., Superintendent, Eloise State Hospital; Henry Cook, M.D., President, Michigan State Medical Society; Albert E. Meader, M.D., Detroit; and Dr. Henry Luce, M.D., President-Elect, Michigan State Medical Society.

The thanks of the Michigan State Medical Society are due the following who traveled from great and near distances to Lansing, and spent the day away from their practices, to attend the "Michigan Health Conference" of September 10. The great massing of physicians testified to the leadership of medical men in Michigan and their tremendous interest in the socio-economic problems facing medicine today. Among the physicians who registered were:

Doctors R. F. Alderman, E. S. Alford, F. T. Andrews, A. J. Baker, H. S. Bartholomew, H. S. Barnard, J. E. Barrett, W. E. Barstow, C. M. Baskerville, Gaylord S. Bates, N. M. Beatty (Indiana), Myron C. Becker, Wm. Behen, Margret Bell, C. H. Belknap, A. V. Van Belois, G. W. Bennett, C. C. Benjamin, C. H. Benning, N. J. Bicknell, W. W. Bond, D. S. Brachman, D. R. Brasie, O. A. Brine, I. W. Brown, J. D. Brooks, R. J. Brown, J. L. Browning, J. D. Bruce, M. D. Bruegel, C. F. Brunk, E. T. Brunson, F. G. Buesser, G. R. Bullen, L. V. Burkett, H. J. Burrell, L. J. Burch, S. A. Butler, G. M. Byington, J. H. Burley, W. J. Cameron, Alice F. Campbell, T. E. Camper, E. I. Carr, H. R. Carstens, A. S. Church, Henry Cook, W. B. Cooksey, H. E. Cope, C. Corley, J. C. Corsaut, B. R. Corbus, Edw. B. Crowley, M. A. Darling, Carleton Dean, W. H. Diebel, R. Dieterle, C. L. DeVries, R. L. Dixon, Douglas Donald, Bruce H. Douglas, Fred J. Drolett, L. A. Drolett, Fred Drummond, E. C. Dunning, C. E. Dutchess, J. F. Failing, F. W. Tamblyn, Chas. A. Tiefer, H. B. Fenech, R. F. Fenton, R. G. Ferris, G. F. Fisher, E. H. Foust, A. V. Forrester, Warren Forsythe, L. Fernald Foster, W.



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## INTERNATIONAL MEDICAL ASSEMBLY

The International Medical Assembly of the Interstate Postgraduate Medical Association of North America will be held in Philadelphia, October 31, November 1, 2, 3, 4, 1938.

### PROGRAM

Monday, October 31

Morning Session, 8:00 A. M.

### DIAGNOSTIC CLINICS:

Acute Coronary Occlusion.

Dr. G. Harlan Wells, Professor and Head of the Department of Medicine, Hahnemann Medical College and Hospital of Philadelphia, Philadelphia, Pennsylvania.

The Significance of Low Back Pain.

Dr. Frank R. Ober, Assistant Dean and John B. and Buckminster Brown Clinical Professor of Orthopedic Surgery, Harvard University Medical School, Boston, Massachusetts; Professor of Orthopedic Surgery, University of Vermont Medical School, Burlington, Vermont.

Present Status of the Treatment of Hirschsprung's Disease.

Dr. Fred Rankin, Lexington, Kentucky.

Hydronephrosis.

Dr. Herman L. Kretschmer, Clinical Professor of Surgery (Genito-Urinary), Rush Medical College, University of Chicago, Chicago, Illinois.

The Significance of Jaundice.

Dr. Henry A. Christian, Hersey Professor of the Theory and Practice of Physic, Harvard University Medical School, Boston, Massachusetts.

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**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technique with practice on living tissue; Clinical Courses; Special Courses. Courses start every Monday.

**GYNECOLOGY**—Two Weeks Course starting October 10th. Gynecological Pathology by Dr. Schiller starting October 24th.

**OBSTETRICS**—Two Weeks Intensive Course starting October 24th. Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course every week; Intensive Formal Course starting February 6th, 1939.

**DERMATOLOGY AND SYPHILOLOGY**—Clinical Course starting every week.

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*Afternoon Session, 1:00 P. M.*

### CHALK TALK:

Trauma of the Larynx.

Dr. Chevalier Jackson, Honorary Professor of Broncho-Esophagology, Temple University School of Medicine, Philadelphia, Pennsylvania.

### DIAGNOSTIC CLINICS:

Postoperative Complications.

Dr. Elliott C. Cutler, Moseley Professor of Surgery, Harvard University Medical School, Boston, Massachusetts.

The Treatment of Anemia.

Dr. Russell L. Haden, Cleveland Clinic, Cleveland, Ohio.

### ADDRESSES

Practical Thyroid and Pituitary Therapy in Problems of Aberrant Growth and Development.

Dr. E. Kost Shelton, Associate Clinical Professor of Medicine, University of Southern California School of Medicine, Los Angeles, California.

Syndromes of Gall Bladder Disease—Surgical Management.

Dr. William D. Haggard, Professor of Clinical Surgery, Vanderbilt University School of Medicine, Nashville, Tennessee.

The Therapeutic Value of Blood Transfusions.

Dr. Cyrus C. Sturgis, Professor of Internal Medicine, University of Michigan Medical School, Ann Arbor, Michigan.

The Surgical Management of Brain Tumors.

Dr. Alfred W. Adson, Professor of Neurosurgery, Mayo Foundation Graduate School of the University of Minnesota; Senior Neurosurgeon of the Mayo Clinic, Rochester, Minnesota.

*Evening Session, 7:00 P. M.*

Obscure Fevers as Diagnostic Problems.

Dr. George Blumer, David F. Smith Clinical Professor of Medicine, Yale University School of Medicine, New Haven, Connecticut.

Treatment of Fracture Dislocations of the Cervical Vertebrae by Skeletal Traction and Fusion.

Dr. William G. Turner and Dr. William Cone, Department of Neurosurgery and Orthopedics, McGill University, the Montreal Neurological Institute and the Royal Victoria Hospital, Montreal, Quebec, Canada.

Complications of Pregnancy.

Dr. Nicholson J. Eastman, Professor of Obstetrics, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Acute Pancreatitis.

Dr. Eldridge L. Eliason, Professor of Surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania, and Dr. William H. Erb by invitation.

The Factors Influencing Operability and Mortality in Carcinoma of the Large Bowel.

Dr. Richard B. Cattell, Lahey Clinic, Boston, Massachusetts.

**Tuesday, November 1**

*Morning Session, 8:00 P. M.*

### DIAGNOSTIC CLINICS

Diagnostic Significance of Pain.

Dr. Frederick J. Kalteyer, Clinical Professor of Medicine, Jefferson Medical College of Philadelphia, Philadelphia, Pennsylvania.

Thyroid Diseases.

Dr. Robert S. Dinsmore and Dr. A. Carlton Ernestine, Cleveland Clinic, Cleveland, Ohio.

Chronic Disease of the Liver.

Dr. Charles A. Elliott, Professor of Medicine, Northwestern University Medical School, Chicago, Illinois.

Clinical Significance of a Lump in the Breast.  
Dr. Edmond M. Eberts, Professor of Surgery,  
McGill University Faculty of Medicine, Montreal,  
Quebec, Canada.

Obstruction of the Neck of the Bladder in Men.  
Dr. William E. Lower, Cleveland Clinic, Cleve-  
land, Ohio.

*Afternoon Session, 1:00 P. M.*

Tic Douloureux.

Dr. Howard C. Naffziger, Professor of Surgery,  
University of California Medical School, San  
Francisco, California.

#### THERAPEUTIC CLINIC

The Treatment of Dehydration and Edema.

Dr. James H. Means, Jackson Professor of Clin-  
ical Medicine, Harvard University Medical School,  
Boston, Massachusetts.

#### ADDRESSES

The Diagnosis and Treatment of Peripheral Nerve  
Injuries.

Dr. Loyal Davis, Professor of Surgery, North-  
western University Medical School, Chicago,  
Illinois.

Immediate and Ultimate Prognosis in Heart Disease.

Dr. Paul D. White, Lecturer in Medicine, Harvard  
University Medical School, Boston, Massachusetts.

Diagnosis and Treatment of Bronchogenic Carci-  
noma.

Dr. Arthur C. Christie, Professor of Clinical  
Radiology, Georgetown University School of  
Medicine, Washington, D. C.

Gastroscopy as an Aid in Diagnosis.

Dr. Chevalier L. Jackson, Professor of Broncho-  
esophagology, Temple University School of Medi-  
cine, Philadelphia, Pennsylvania.

Adenomatous Thyroid With and Without Hyper-  
thyroidism—Medical and Surgical Aspects.

Dr. Charles W. Mayo, Assistant Professor of  
Surgery, and Dr. Samuel F. Haines, Assistant  
Professor of Medicine, University of Minnesota  
Graduate School of Medicine, Mayo Clinic,  
Rochester, Minnesota.

*Evening Session, 7:00 P. M.*

Diagnosis and Treatment of Carcinoma of the  
Fundus of the Uterus.

Dr. Floyd E. Keene, William Goodell Professor  
of Gynecology, University of Pennsylvania School  
of Medicine, Philadelphia, Pennsylvania.

The Present Status of Our Knowledge of Anterior  
Poliomyelitis.

Dr. John C. Gittings, William H. Bennett Profes-  
sor of Pediatrics, University of Pennsylvania  
School of Medicine, Philadelphia, Pennsylvania.

The Diagnosis and Treatment of Splenomegaly.

Dr. Allen O. Whipple, Valentine Mott Professor  
of Surgery, Columbia University College of Physi-  
cians and Surgeons, New York, New York.

Neoplasms of the Stomach; Correlation of Roent-  
genological and Clinical Aspects.

Dr. Fred J. Hodges, Professor of Roentgenology,  
University of Michigan Medical School, and Dr.  
Robert M. Bartlett, Instructor in Department of  
Surgery, University of Michigan Medical School,  
Ann Arbor, Michigan.

The Use of Spinal Anesthesia.

Dr. Thomas H. Russell, Professor of Clinical  
Surgery, New York Postgraduate Medical School,  
Columbia University, Executive Officer and Direc-  
tor of Department of Surgery, New York Post-  
graduate Medical School and Hospital, New York,  
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Wednesday, November 2

Morning Session, 8:00 A. M.

### DIAGNOSTIC CLINICS

Diagnosis and Treatment of Spinal Cord Tumors.  
Dr. Walter E. Dandy, Adjunct Professor of Neurological Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland.  
Differential Diagnosis of Acute Abdominal Disease.  
Dr. Claude F. Dixon, Associate Professor of Surgery, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minnesota.  
Diabetes Mellitus From an Endocrinological Viewpoint.  
Dr. Elliott P. Joslin, Clinical Professor of Medicine, Harvard University Medical School, Boston, Massachusetts.  
Dr. Oliver S. Ormsby, Clinical Professor of Dermatology, Rush Medical College, University of Chicago, Chicago, Illinois.  
Treatment of Complicated Colles' Fractures.  
Dr. William Darrach, Dean Emeritus and Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons, New York, New York.

Afternoon Session, 1:00 P. M.

The Indications, Contraindications, and End-Results in the Surgical Treatment of Essential Hypertension.  
Dr. George Crile, Cleveland Clinic, Cleveland, Ohio.

### ADDRESSES

Hyperpyrexia by Physical Agents; Technic, Indications and Results.  
Dr. John S. Coulter, Associate Professor of Physical Therapy, Northwestern University Medical School, Chicago, Illinois.  
Clinical Significance of Hematuria.  
Dr. William F. Braasch, Professor of Urology, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minnesota.  
A Medical Appraisal of the Surgery of Pulmonary Tuberculosis.  
Dr. William S. Middleton, Dean and Professor of Medicine, University of Wisconsin Medical School, Madison, Wisconsin.  
The Clinical Use of Sulfanilamide in Infectious Diseases.  
Dr. Perrin H. Long, Associate Professor of Medicine, Johns Hopkins University School of Medicine, Lecturer in Epidemiology, Johns Hopkins School of Hygiene and Public Health, Associate Physician Johns Hopkins Hospital, Baltimore, Maryland.  
Acute Appendicitis: Management and Mortality.  
Dr. George P. Muller, Professor of Surgery, Jefferson Medical College, Philadelphia, Pennsylvania.  
Injuries to the Heart, Stab Wounds, and Contusions.  
Dr. Claude S. Beck, Associate Professor of Surgery, Western Reserve University School of Medicine, Cleveland, Ohio.  
Improvements in Methods of Abdominal Drainage.  
Dr. W. Wayne Babcock, Professor of Surgery and Clinical Surgery, Temple University School of Medicine, Philadelphia, Pennsylvania.

Thursday, November 1

Morning Session, 8.00 A. M.

### DIAGNOSTIC CLINICS

Role of Diseases of the Sinuses to General Medicine.  
Dr. Robert F. Ridpath, Professor of Laryngology and Rhinology, Temple University School of Medicine, Philadelphia, Pennsylvania.

The Significance of Enlargement of the Abdomen in Children.

Dr. Irvine McQuarrie, Professor of Pediatrics, University of Minnesota Medical School, Minneapolis, Minnesota.

The Diagnosis of Bone Lesions.

Dr. Dean Lewis, Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Non-Organic Disorders of the Digestive Tract.

Dr. Alfred Stengel, Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Somatic Complaints in the Neuroses: Case Presentations.

Dr. Peter T. Bohan, Professor of Clinical Medicine, University of Kansas School of Medicine, Kansas City, Missouri.

*Afternoon Session, 1:00 P. M.*

Immediate Care of Fractures.

Dr. Clay Ray Murray, Associate Professor of Surgery, Columbia University College of Physicians and Surgeons, New York, New York.

Hodgkin's Disease.

Dr. Warfield T. Longcope, Professor of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland.

#### ADDRESSES

Immediate Versus Delayed Surgery in the Treatment of Acute Diseases of the Gall Bladder.

Dr. Charles Gordon Heyd, Professor of Clinical Surgery, New York Postgraduate Medical School, Columbia University, New York, New York.

The Management of Peritonitis.

Dr. Vernon C. David, Clinical Professor of Surgery, Rush Medical College, University of Chicago, Chicago, Illinois.

Osteomyelitis of the Frontal Bone.

Professor Dr. v. Eicken, Department of Otolaryngology, Medical Faculty University of Berlin, Berlin, Germany.

The Object and the Value of Preoperative and Postoperative X-ray Treatment in Carcinoma of the Breast.

Dr. George E. Pfahler, Professor of Radiology, University of Pennsylvania Graduate School of Medicine, Philadelphia, Pennsylvania.

Subtemporal Decompression; Indications and Surgical Technic.

Dr. Eric Oldberg, Professor and Head of the Department of Neurology and Neurological Surgery, University of Illinois College of Medicine, Chicago, Illinois.

Relation of Trauma to Inguinal Hernia; Analysis of 1,000 Herniotomies.

Dr. John J. Moorhead, Professor of Clinical Surgery, New York Postgraduate Medical School, Columbia University, New York, New York.

*Evening Session, 7:00 P. M.*

Classification and Treatment of the Epilepsies.

Dr. Wilder Penfield, Professor of Neurology and Neurosurgery, McGill University Faculty of Medicine; Director of Montreal Neurological Institute, Montreal, Canada.

The Clinical Significance of Retinal Charges in Arterial Hypertension. The Joseph Schneider Foundation Presentation.

Dr. Walter I. Lillie, Professor of Ophthalmology, Temple University School of Medicine, Philadelphia, Pennsylvania.

The Prognosis and Treatment of Rheumatic Heart Disease.

Dr. Fred M. Smith, Professor of Theory and Practice of Medicine, State University of Iowa College of Medicine, Iowa City, Iowa.



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Psychotherapy in General Medicine.

Dr. Clarence B. Farrar, Professor of Psychiatry, University of Toronto Faculty of Medicine, Toronto, Canada.

Pellagra.

Dr. John H. Musser, Professor of Medicine, Tulane University of Louisiana School of Medicine, New Orleans, Louisiana.

Friday, November 4

Morning Session, 8:00 A. M.

#### DIAGNOSTIC CLINICS

Carcinoma of the Larynx with Special Reference to End-Results.

Dr. Louis H. Clerf, Professor of Laryngology and Bronchoscopy, Jefferson Medical College, Philadelphia, Pennsylvania.

Compressed Fractures of the Vertebrae.

Dr. Hubley R. Owen, Professor of Clinical Surgery, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania.

The Management of Gastric and Duodenal Ulcer, Jejunal Ulcer, and Gastrojejunal Colic Fistula.

Dr. Frank Lahey, Lahey Clinic, Boston, Massachusetts.

The Differential Diagnosis of Diseases of the Chest and Abdomen.

Dr. David Riesman, Emeritus Professor of Clinical Medicine and Professor of History of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania.

Diagnosis and Treatment of Obstructive Lesions of the Colon.

Dr. John F. Erdmann, Attending Surgeon, New York Postgraduate Medical School, New York, New York.

Afternoon Session, 1:00 P. M.

Treatment of Fractures of the Neck of the Femur by Internal Fixation.

Dr. M. N. Smith-Petersen, Clinical Professor of Orthopedic Surgery, Harvard University Medical School, and Chief of Orthopedic Service, Massachusetts General Hospital, Boston, Massachusetts.

Complications Following Surgery of the Biliary Tract.

Dr. Waltman Walters, Professor of Surgery, University of Minnesota Graduate School of Medicine, Mayo Clinic, Rochester, Minnesota.

#### ADDRESSES

The Present Status of Our Knowledge of the Suprarenal Cortical Hormone.

Dr. George A. Harrop, Director of Research, E. R. Squibb & Sons, New Brunswick, New Jersey.

Obstruction of the Neck of the Bladder in Women.

Dr. Hugh H. Young, Professor of Urology, Johns Hopkins University School of Medicine, Baltimore, Maryland.

Studies in Growth—Precocious and Malignant.

Dr. Leonard G. Rowntree, Director, Philadelphia Institute for Medical Research, Philadelphia, Pennsylvania.

Trauma of the Abdomen.

Dr. Arthur R. Metz, Associate Clinical Professor of Surgery, Rush Medical College, University of Chicago, Chicago, Illinois.

Influenza Pneumonias: Observations on Their Pathological Features and Clinical Characteristics.

Dr. Robert G. Torrey, Professor of Medicine, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania.

The Treatment of Bronchiectasis.

Dr. Edward D. Churchill, John Homans Professor of Surgery, Harvard University Medical School, Boston, Massachusetts.

## IN MEMORIAM

Dr. William A. Hackett

Dr. William A. Hackett, long a resident and one of the older practitioners in Detroit, died on September 19. Dr. Hackett had been ailing for nearly a year with cancer of the bladder. He was born in Ontario seventy years ago and, following his graduation from the medical school of the University of Toronto, he located in Detroit, where he had been in practice up to the time of his death. He is survived by his wife and one brother, Dr. Walter L. Hackett, who is in practice in Detroit. The late Dr. Hackett was well known. He was one of the founders of the Samaritan Hospital, later to become St. Joseph's Mercy Hospital, on East Grand Boulevard, Detroit. Dr. Hackett continued to be a member of the staff of St. Joseph's Mercy Hospital up to the time of his death. He was quiet, of a gentle nature, which inspired confidence in his large practice. Dr. Hackett was a member of the Wayne County and Michigan State Medical Societies and the American Medical Association.

#### Purse-string Puppetry

(*New York State Journal of Medicine*)

The use of the WPA to influence political elections should serve as a warning to those who urge further extension of governmental control over private enterprise. When a large proportion of the population is attached to the public purse-strings, the Administration in power is enabled to wield an unwholesome influence over political events.

Medicine has frequently cited the danger of political domination among its reasons for opposition to obligatory sickness insurance. Current attempts to influence the outcome of primaries through Administration pressure on WPA workers prove that this is no chimera.

There are many ways in which political dissidents on the medical panels could be made to feel the administrative lash. The vast amount of form-filing required of panel doctors provides an ever-present excuse for punitive action. Clerical errors could be made a reason for withholding pay checks. There are a thousand other petty devices by which friendly superiors could help, and hostile ones obstruct, insurance practitioners.

It is not merely his political independence which the physician forfeits to compulsory sickness insurance. As experience in Europe proves, his professional independence is even more directly threatened. Unchecked by any necessity to pay for service, the demands of panel patients are frequently unreasonable and excessive. Often, they clash with administrative policy. Caught between two millstones, the unhappy practitioner is forced to subordinate his honest judgment to expediency. The inevitable result is a loss of professional morale and a drop in professional standards.

Free from political interference, the American doctor has raised medical care to a level equalled in few countries and surpassed in none. Certainly, no nation with compulsory sickness insurance offers its laboring classes service comparable to that enjoyed by the American worker.

It would be a great pity if bureaucratic control were allowed to reduce the political and professional standards of the medical profession to those of the WPA.

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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**A TEXTBOOK OF GYNECOLOGY.** By Arthur Hale Curtis, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, Northwestern University Medical School; Chief of the Gynecological Service, Passavant Memorial Hospital, Chicago, Illinois. Third Edition, Reset. 603 pages with 318 illustrations. Cloth, \$7.00 net. Philadelphia and London: W. B. Saunders Company, 1938.

Were this third edition of the author's work simply a revision, very little would require to be said. The author's work is too well known to call for a detailed introduction to the medical profession, so that a third revision would ordinarily mean only those changes, deletions and insertions to keep the work abreast with current teaching of gynecology. However, in this third edition, the author has not only entirely rewritten the second edition; he has added eight chapters preliminary to the former work. The first comprises over sixty pages on the anatomy of the female genitalia; the second deals with the embryology; the third and fourth discuss the function, exclusive of the endocrine glands; the fifth, sixth, seventh and eighth are devoted to endocrine glandular physiology. A feature of the work that is deserving of special comment consists of the drawings and illustrations by the anatomical illustrator. Dr. Curtis has covered thoroughly the literature on the subject and has appended workable bibliographies to each chapter. Even with the eight additional chapters, the author has kept his book within six hundred pages. This work can be unreservedly recommended to the class of physician for whom it is intended, the general practitioner, the medical student as a teachable textbook and it will be appreciated most of all by the gynecologist.

**EXPERIENCE IN THE MANAGEMENT OF FRACTURES AND DISLOCATIONS** (Based on an Analysis of 4,390 Cases). By the Staff of the Fracture Service, Massachusetts General Hospital, Boston, Under the Editorship of Philip D. Wilson, M.D. 1036 Pages, 1419 Illustrations. Price \$15.00. Philadelphia: J. B. Lippincott Company.

There is no work on surgery more important than a volume on fractures and dislocations. This is truer today than ever before, considering the tempo of life in industry and on the roads. This book is unique inasmuch as it deals with special instances of fracture rather than a general discussion of types of fracture. The composite authorship insures a special emphasis that is not possible in a general work by a single author. The fracture service of the Massachusetts General Hospital in a large city, Boston, is comparable with Detroit with its Receiving Hospital. The Management of Fractures and Dislocations presents not only a large number of specific cases while under treatment, but actual examination of the patients a year or more after their discharge from the hospital with an appraisal of results in terms of anatomic restoration, restoration of function and ability to work. Special attention has been paid to unsatisfactory results. Not only have we a clear, concrete text, the authors have made copious use of illustrations. The work is highly recommended to the surgeon, the orthopedist and the general practitioner. While fractures and dislocations are the domain of the orthopedist, the major portion will be treated in general practice. This work is unique.

**THE TROUBLED MIND, A STUDY OF NERVOUS AND MENTAL ILLNESSES.** By C. S. Bluemel, M.A., M.D., F.A.C.P., M.R.C.S. (Eng.). Price \$3.50, pages 520. Baltimore: The Williams and Wilkins Company, 1938.

Now that mental hygiene has come to occupy such an important place with physicians, who are not psychiatrists, this work will be found very helpful. The writer has illustrated the book copiously by means of case histories. Many are of incipient or borderline cases of mental illness which with the advice of the physician and coöperation of the patient should progress to recovery. The numerous histories given will be found interesting to the internist or general practitioner who meets with similar symptoms in his patients, almost daily. They suggest the necessity of a thorough physical examination to eliminate possible organic disease before concluding that the patient is a mental patient. Not much, however, is presented in the matter of treatment, which consists of the concluding chapter of six pages. The reviewer would have preferred it had the author gone more extensively into psychotherapy. We are left with the feeling that the patient's coöperation is a large factor in "ministering to a mind diseased." However, the book is intended for the more advanced general reader as well. A glossary of medical terms is appended to help him on with the technical terms peculiar to this branch of medicine. The author includes an interesting chapter on "The Public Lunatic," who he claims is the more dangerous because his lunacy is not generally recognized. In the class he places the seeker after political power, the dictator, as well as certain types of evangelists. The aggressive psychopath who gets into public life may be the cause of social and industrial unrest. The book is not intended for the specialist, the psychiatrist. To repeat, it is a very valuable contribution to the subject of mental hygiene.

**THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY:** A complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut.-Colonel, M.R.C., U. S. Army; Member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association; Editor of the "American Pocket Medical Dictionary." With the Collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Eighteenth Edition, Revised and Enlarged. 1,607 pages with 942 illustrations, including 283 portraits. Flexible and Stiff Binding. Philadelphia and London: W. B. Saunders Company, 1938. Plain, \$7.00 net. Thumb Indexed, \$7.50 net.

Probably there is no better way of estimating the growth of a science than the perusal of a dictionary of the terms of that science. This is the eighteenth revision of the American Dictionary by Dorland since nineteen hundred, a new edition almost every two years. Over three thousands words have been included since the last revision. This has necessitated an increase of over sixty pages. In spite of a total of 1,607 pages, due to the quality of paper and the arrangement, the volume is convenient for ready reference. While the entire field of medicine is involved in the new words, the largest additions will be found in the fields of endocrinology, immunology, pathology, clinical medicine and dentistry. The plan of former editions has been followed. The word to be defined is in boldfaced type, followed by phonetic pronunciation, also, the etymology, usually Latin or Greek. The Greek alphabet is used in giving the etymology of Greek derivatives. Then follows a clear, simple definition. This dictionary is highly recommended not only to the physician and dentist as such but to the medical writer of either class.



## ◆ Among Our Contributors ◆

**Dr. J. H. Ahronheim** is pathologist to Foote Memorial and Mercy Hospitals, Jackson, Michigan. He was graduated from the University of Berlin in 1931 and received his training in pathology under the German pathologist, Dr. Ludwig Pick, and under Dr. C. V. Weller, University of Michigan. He has held his present position since October, 1936.

**Dr. John A. Larson** received the degree of A.B. also A.M. at Boston University in 1914 and 1915, respectively, Ph.D. in Physiology and Biochemistry from the University of California in 1920, and M.D. from Rush Medical School, University of Chicago in 1928. He has taken up graduate studies in criminology. Dr. Larson had four years of practical police work and research in the Berkeley, California, Police Department, also four years as Research Psychologist for the Illinois Institute for Juvenile Research. He has been teaching psychiatry for nine years in the medical schools of Johns Hopkins, Iowa and Rush College of the University of Chicago.

**Dr. Winfred Overholser** was graduated A.B. from Harvard in 1912 and M.D. from Boston University School of Medicine in 1916. He served at the Massachusetts State Hospital from 1917 to 1936, was Commissioner of Mental Diseases from 1934 to 1936, and formerly Professor of Psychiatry, Boston University. Dr. Overholser is Chairman of the Section on Forensic Psychiatry of the American Psychiatric Association and is a diplomate of the American Board of Psychiatry and Neurology.

**Dr. Lowell S. Selling** is the Director of the Recorder's Court, Psychopathic Clinic, and Assistant Attending Neuropsychiatrist at Eloise Hospital, and also Adjunct Neuropsychiatrist at Harper Hospital. He is a graduate of Bellevue Hospital Medical College, and Ph.D. in Psychology from Columbia University. He is the author of a book "Diagnostic Criminology," and many other publications.

**Dr. C. Fremont Vale** is a graduate of the University of Pennsylvania, 1916; interned at Lankenau Hospital, Philadelphia, 1916-18. He is Professor of Clinical Surgery at Wayne University, College of

Medicine. He is a Fellow of the American College of Surgeons and a Founder Member of the American Board of Surgery.

**Dr. George L. Waldbott** is a graduate of the University of Heidelberg, Germany, 1921. His specialty is allergy and he is in charge of the Clinics at Grace and Harper Hospitals, also the North End Clinic.

**Dr. L. M. Warfield** is a graduate of Johns Hopkins Medical School, 1901, he is Specialist in Internal Medicine, formerly Professor of Medicine and Head of the Department at University of Michigan (1922-1924). At present he is practicing Internal Medicine in Milwaukee.

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# COUNTY SOCIETIES

## BRANCHES OF THE MICHIGAN STATE MEDICAL SOCIETY

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETING	
			Regular	Annual
Allegan .....	E. T. BRUNSON Ganges	M. B. BECKETT Allegan	1st Tuesday	1st Tuesday December
Alpena-Alcona- Presque Isle.....	W. E. NESBITT Alpena	HAROLD KESSLER Alpena	Last Thursday 6:00 p. m.	Last Thursday December
Barry .....	G. F. FISHER Hastings	THOMAS H. COBB Woodland	2nd Thursday 8:00 p. m.	1st Thursday January
Bay-Arenac-Iosco- Gladwin .....	C. L. HESS Bay City	A. L. ZILIAK Bay City	2nd and 4th Wednesday (ex- cept July, Aug., Sept.) 6:00 p. m.	2nd Wednesday December
Berrien .....	HARRY KOK Benton Harbor	A. F. BLIESMER St. Joseph	2nd Wednesday or Thursday	2nd Wednesday or Thursday, December
Branch .....	N. S. ALDRICH Coldwater	F. S. LEEDER Coldwater	3rd Thursday 6:30 p. m.	3rd Thursday December
Calhoun .....	J. E. ROSENFELD Battle Creek	WILFRID HAUGHEY Battle Creek	1st Tuesday (except July and Aug.)	1st Tuesday December
Cass .....	K. C. PIERCE Dowagiac	GEO. LOUPEE Dowagiac	2nd Wednesday or Thursday	December 15
Chippewa- Mackinac .....	J. F. DARBY St. Ignace	DWIGHT F. SCOTT Sault Ste. Marie	1st Thursday 7:30 p. m.	1st Thursday December
Clinton .....	F. E. LUTON St. Johns	T. Y. HO St. Johns	Last Tuesday (Oct. to June, incl.)	Last Tuesday October
Delta .....	W. A. LEMIRE Escanaba	G. W. BENSON Escanaba	1st Thursday 8:30 p. m.	December 2
Dickinson-Iron .....	L. E. IRVINE Iron River	W. H. HURON Iron Mountain	1st Thursday 6:30 p. m.	1st Thursday December
Eaton .....	H. A. MOYER Charlotte	THOMAS WILENSKY Eaton Rapids	3rd Thursday	No set date
Genesee .....	A. McARTHUR Flint	C. W. COLWELL Flint	2nd and 4th Tuesday (ex- cept July and August)	2nd Tuesday November
Gogebic .....	CHAS. E. ANDERSON Bessemer	WM. H. WACEK Ironwood	3rd Tuesday	3rd Tuesday December
Grand Traverse- Leelanau-Benzie	MARK OSTERLIN Traverse City	C. E. LEMEN Traverse City	1st Tuesday 8:00 p. m.	1st Tuesday December
Gratiot-Isabella- Clare .....	C. M. BASKERVILLE Mt. Pleasant	RICHARD L. WAGGONER St. Louis	3rd Thursday	3rd Thursday December
Hillsdale .....	W. E. ALLEGER Pittsford	E. G. McGAVRAN Hillsdale	Last Thursday	Last Thursday December
Houghton-Baraga- Keweenaw .....	R. S. BUCKLAND Baraga	C. A. COOPER Hancock	1st Tuesday	1st Tuesday January
Huron-Sanilac .....	R. R. GETTEL Kinde	E. W. BLANCHARD Deckerville	2nd Thursday	2nd Thursday December
Ingham .....	DANA M. SNELL Lansing	R. J. HIMMELBERGER Lansing	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Ionia-Montcalm ....	R. R. WHITTEN Ionia	JOHN J. McCANN Ionia	2nd Tuesday 7:00 p. m.	2nd Tuesday December
Jackson .....	JOHN VAN SCHOICK Hanover	H. W. PORTER Jackson	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kalamazoo- Van Buren .....	R. J. HUBBELL Kalamazoo	L. W. GERSTNER Kalamazoo	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kent .....	A. J. BAKER Grand Rapids	J. M. WHALEN Grand Rapids	2nd and 4th Wednesday 8:15 p. m.	2nd Wednesday December
Lapeer .....	G. C. BISHOP Almont	C. C. JACKSON Imlay City	2nd Thursday	December or January
Lenawee .....	CHAD A. VAN DUSEN Blissfield	ESLI T. MORDEN Adrian	3rd Tuesday	3rd Tuesday October
Livingston .....	BERNARD H. GLENN Fowlerville	DUNCAN C. STEPHENS Howell	1st Friday 6:30 p. m.	1st Friday December
Luce .....	A. T. REHN Newberry	C. D. HART Newberry	1st Tuesday 8:00 p. m.	1st Tuesday December
Macomb .....	JOSEPH N. SCHER Mt. Clemens	R. F. SALOT Mt. Clemens	1st Monday 12:00 noon	1st Monday December
Manistee .....	KATHRYN BRYAN Manistee	C. L. GRANT Manistee	Every Monday noon	1st Monday December
Marquette-Alger ....	N. J. McCANN Ishpeming	D. P. HORNBOKEN Marquette	No set date	December
Mason .....	V. J. BLANCHETTE Custer	CHAS A. PAUKSTIS Ludington	2nd Tuesday	2nd Tuesday December
Mecosta-Osceola ...	L. F. CRESS Reed City	GLENN GRIEVE Big Rapids	2nd Tuesday	2nd Tuesday December

## COUNTY SOCIETIES

Menominee .....	JOHN TOWEY Powers	WM. S. JONES Menominee	3rd Thursday	3rd Thursday December
Midland .....	CHAS. L. MacCALLUM Midland	N. C. GREWE Midland	2nd Thursday	2nd Thursday December
Monroe .....	W. J. GELHAUS Monroe	FLORENCE AMES Monroe	3rd Thursday (except July and Aug.)	3rd Thursday October
Muskegon .....	CHAS. A. TEIFER Muskegon	L. E. HOLLY Muskegon	Last Friday 6:00 p. m.	2nd Friday December
Newaygo .....	LAMBERT GEERLINGS Fremont	W. H. BARNUM Fremont	As called	3rd Tuesday December
Northern Mich. (Antrim- Charlevoix- Emmet- Cheboygan) .....	B. H. VANLEUVEN Potoskey	W. E. LARSON Levering	2nd Thursday 6:00 p. m.	2nd Thursday December
Oakland .....	AARON RIKER Pontiac	O. O. BECK Birmingham	1st Wednesday (except July and Aug.)	1st Wednesday December
Oceana .....	MERLE G. WOOD Hart	N. W. HEYSETT Hart	No definite date set	December
O.M.C.O.R.O. (Otsego- Montmorency- Crawford-Oscoda- Roscommon- Ogemaw) .....	LEVI A. HARRIS Gaylord	C. G. CLIPPERT Grayling	On call	December
Ontonagon .....	F. W. McHUGH Ontonagon	E. J. EVANS Ontonagon	On call	January
Ottawa .....	GERRIT KEMME Zeeland	D. C. BLOEMENDAL Zeeland	2nd Tuesday Noon	2nd Tuesday December
Saginaw .....	W. K. ANDERSON Saginaw	H. C. WALLACE Saginaw	3rd Tuesday 8:30 p. m.	3rd Tuesday December
Schoolcraft .....	A. R. TUCKER Manistique	GEO. A. SHAW Manistique	On call	January 10
Shiawassee .....	W. E. WARD Owosso	R. J. BROWN Owosso	3rd Thursday Noon	3rd Thursday December
St. Clair .....	C. A. MacPHERSON St. Clair	JACOB H. BURLEY Port Huron	1st and 3rd Tuesdays Oct. to June	3rd Tuesday December
St. Joseph .....	R. A. SPRINGER Centreville	JOHN W. RICE Sturgis	1st Thursday 6:30 p. m.	1st Thursday January
Tuscola .....	LLOYD L. SAVAGE Caro	R. R. HOWLETT Caro	2nd Thursday 8:00 p. m.	2nd Thursday November
Washtenaw .....	S. L. LaFEVER Ann Arbor	Wm. M. BRACE Ann Arbor	2nd Tuesday	2nd Tuesday December
Wayne .....	HENRY R. CARSTENS Detroit	B. I. JOHNSTONE Detroit	Every Monday 8:45 p. m. (Oct. to May, incl.)	3rd Monday in May
Wexford- Kalkaska- Missaukee .....	L. E. SHOWALTER Cadillac	B. A. HOLM Cadillac	Last Thursday	Last Thursday October

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# HACK'S FOOT NOTES

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*Shoe Information for the Profession*

by the Hack Shoe Co., Inc.

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Vol. VIII

Detroit, Michigan, October, 1938

No. 10

## “THE FORGOTTEN FOOT”

“The Forgotten Foot” is remembered to the extent of a full chapter in Waddington’s\* new book, “Physical Therapy, Theoretical and Clinical.” He states, “No physical examination can be considered complete without a thorough foot and postural investigation; . . . this naturally implies careful investigation of the footgear.”

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\*Waddington, Jos. E. G., “Physical Therapy, Theoretical and Clinical,” Bruce Publishing Co., St. Paul, 1938.

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# THE JOURNAL

OF THE

*Michigan State Medical Society*

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 37

NOVEMBER, 1938

No. 11

## PUBLIC HEALTH THE PRODUCT OF INDIVIDUAL PREVENTIVE MEDICINE\*

HAVEN EMERSON, M.D.  
NEW YORK CITY

High is the purpose and fortunate the occasion when men and women gather to pay a tribute of attention to that incomparable treasury of knowledge, preventive medicine, which holds the power of making human life a triumphant experience in happiness.

You, here in presence, whether disciples of that practice of human biology which we call medicine, or representatives of the households of Michigan, and your innumerable fellows in hospitals, offices, cities and farms of this far flung state, are all for this brief period concerned with the use and value, the method and purpose of those sciences and arts upon which a great share, if not the whole substance, of our social survival now depends.

History teaches us that at least three kinds of efforts to control man and his society, his aggregate or collective existence, have swept over the world, and even while we hold our breath a repetition of the cycle seems imminent. Force of arms, spiritual revolution, and commerce has each in turn possessed itself of the bodies and souls of men. Of the military empires from earlier centuries none remain. The dynasties of religion play an ever shrinking role where once they dominated human conduct. We are in the very midst of that collapse of international commerce, and almost of that

personal trade which lives by fair return for honest labor, which for the last hundred years have been the working philosophy of men and nations, the economies and sociology of a Victorian and pre-war civilization.

Are we to watch, fascinated and inactive, a new onslaught by state or race upon man's potential development, a direct attack upon his social and self-determination, a blocking of his progress towards higher attainments of body and mind for his family and his future?

Our answer to the threat of wars of aggression, to the temporal empires of religion, and to the conflict between capital and labor, government and industry, producer and consumer, can perhaps contribute something helpful.

Medicine is but the name of a vast trusteeship built upon the searching and answers which men of all centuries have recorded in matters of human life. First, and inevitably so, was the study of sickness, pain, misery, of body and mind. The heart and compassion of his fellows could but respond by efforts at relief of suffering.

\*The Andrew P. Biddle Oration in connection with the Annual Meeting of the Michigan State Medical Society for 1938 was delivered by Dr. Haven Emerson of New York, on September 21. Dr. Emerson was introduced by Dr. Angus McLean. Following this lecture, Dr. Emerson was presented with the Biddle Oration Scroll. The lecture was very well received and now that we are privileged to give it a permanent place, we recommend that it be read not only by those whose good fortune it was to hear it, but by those members of our society who were unable to be present.—EDITOR.



Out of this has come 2,300 years of the traditional practice of medicine, a history of uneven progress towards that, so great but still only partial, measure of present success in diagnosis and treatment of disease, which demands the most rigorous discipline of education and most intimate and confidential reciprocal relations between patient and physician, both precious and respected.

### Medicine Preventive Rather Than Curative

For not more than a hundred years medicine has engaged in an application of its accumulated experience with the natural history of disease, for the purpose of preventing those illnesses for which the cause was both known and controllable. So rapidly have physicians and their collaborators among the biologists, chemists, physicists and sanitarians added to the list of preventable diseases that it is now a question whether a larger fraction of the available personnel of the medical and associated professions is not actually devoted to the control of these than is engaged in the cure of the sick. What was but a few decades ago the interest of a handful of investigators or officers of departments of health is now the preoccupation of a growing army serving science, society, and the individual, industry, government and the family for the protection of the health of man. Never before were such sums devoted by taxpayers, by philanthropy and education, by industry and commerce, to the advancement of our knowledge of preventable disease and to the practical application of this in the saving of life. But even such advance from care of the sick to prevention of disease neither satisfied the ambition of students of the medical sciences nor checked the progress of ideas towards an even more influential field of effort, that of creative medicine, the development of health, not only safeguarding what we have but taking steps to improve upon it. Conscious determination to add to the sum, duration or quality of human health could hardly fail to follow the phenomenal mastery over the living plants of field, farm, and garden, the animals of burden, sport or food which the biologists have achieved. It was not enough that man could control his environment and his nurture, but he must take thought also of his nature, his origins, the living sequence of his own qualities and the significance of these for the following generations. So, although

this is still preventive medicine, it is at another level, contemplating in its scope the use of man's highest mental and spiritual qualities of self-control and of creation. Included within the field of such creative medicine is what Galton defined as eugenics, "the study of agencies under social control that may improve or impair the racial qualities of future generations either physically or mentally." In other words, medicine of today acknowledges its concern with heredity as a practical factor, to be dealt with in the interest of health, and as a means of preventing disease.

\* \* \*

How then is medicine prepared to meet the challenge, to carry into the realm of accomplishment the resources it now holds for man's benefit? Is it necessary or desirable to transfer unto government those functions and relationships now possessed by the physicians? What are the activities contributory to health which can be carried on only by government? What is the necessary share of the individual whose health we seek to benefit? Is there one plan for national health that will meet the pattern of thought of each community in the varied mosaic of our nation, and who shall do the planning?

These and similar queries must be answered before we can acquire a sense of direction in our further quest for the Grail of Health.

\* \* \*

Since the development of creative or eugenic medicine is still in the stage of intellectual and social exploration, and with a few exceptions hardly yet comes within the range of general application, we can best analyze the situation under the two main divisions of so-called curative and preventive medicine, both of which are best applied through the ministrations of the private practitioner of medicine.

### Distribution of Medical Care

For the diagnosis and treatment of the sick the only serious criticism sustained by reasonable evidence is that the physician does not automatically seek as places for residence those areas or communities where the people are too poor to meet his reasonable expectation of a livelihood. Remedy for this is either social or governmental guarantee or subsidy to the physician of an income sufficient to attract one of suitable



qualifications to these relatively less promising localities. True, there is a small fraction (about one and a half per cent) of the population not yet within an hour's motor ride, or thirty miles, of an approved hospital, and in some instances the hospital nearest may not be prepared to meet the needs of the patient at hand. Tax money may be justified in increasing the availability of hospital care of an acceptable character to all but the most remote and lonely dweller of our population. It is not an organization of physicians to serve, nor their regimentation by government that is needed to remedy the present inequalities of their distribution, but the facilitation of the necessary habits of organized thrift and forethought among the people which will make it possible for the family, or the group, or if necessary the community, to pay for the cost of sickness which would be beyond the means of the individual to meet. The medical profession is committed to a policy of high standards of education and licensure, and of a method of professional self-discipline and a quality of performance which is not likely to be bettered by vesting such responsibility in officers of civil government.

There are eight subdivisions of institutional care of the sick which society, at least in our large, and in many of the better organized smaller cities and adjacent counties, has found necessary or desirable in the interest of medical efficiency and economy, and these have the approval and active coöperation of the participating physicians, and could not have survived unless they had proved their practical necessity, and staff standards of professional conduct were in effect. To list these forms of institutional care of the sick will suffice for such an audience as this. The hospital, the out-patient service, visiting nursing, medical social work, ambulance service, the convalescent home, the hospital for the chronically ill, and home medical care for those eligible for but not requiring free hospital care. These institutions and agencies representing organized care of the sick, together with the services of the individual practitioner of medicine, have achieved an extent and quality of medical services in this country which have not in the past been available or equalled for any similarly extensive or varied population in other continents. This has been achieved without hardship to the sick or to the taxpayer and

without creating abuses of monopoly or privilege leading to excessive incomes among physicians. Admittedly imperfect in quality and quantity for certain fractions of our national population, medical care in sickness is likely to continue its really remarkable improvement of the past half century better by reliance upon the forces inherent in the medical profession and by the reasonable demand of patients and their families than by the intervention of the interests of government or by the proposals of economists, sociologists and politicians.

### Responsibility of Laity

For the prevention of disease and the protection of health there are many shortcomings in our plans and performance. These can honestly be laid to the door of the laity rather than be charged against medical incompetence or unwillingness. And yet by any measure we can apply through historical comparison or contemporary statistics we do now appear to be at the very zenith of a period of amazing improvement in health. In fact, never before has any substantial part of our population, nor has at any time in the recorded history of man, any population of such size, diversity of racial, climatic and social conditions in any other continent or under one government been so relatively free from communicable disease, so likely to have its children survive the hazardous years of infancy and early childhood, or to so nearly approach the biblical term of years of life.

If, as the spokesmen and women of technical committee and interdepartmental board in Washington have recently announced "the facilities for public health are grossly insufficient," it may be well to remind them that it is not by their efforts that we have reached the summit of the foothills of health, and that less extravagance of statement would better become a federal government which now offers little new to us, other than to put our children and grandchildren more deeply into debt for their health, so that it, the present federal administration, may claim merit for doing suddenly and at great cost, what society and medicine have been achieving slowly, steadily and surely within the means of thrifty communities to pay as they go. True there are mountains of unnecessary disease and human suffering to be tunneled, scaled, or worn down by the gradual erosion



of scientific progress, but human biology can rarely be hurried, even by billions, and it has a way of making its more enduring advances in human survival by evolution rather than by revolutionary variants in social method.

### Public Health, What Is It?

What in fact is this we speak of as public health? Is there such an entity? Is there a quality or property of societies, of units of population, of organized communities which we can describe as public health? Or are we using a term which diverts us from the understanding of the truth, while catching the ready ear of the unthinking throng?

Health is individual, personal, a quality of man, of his wife, of their child. It is what the person, within the limits of his inherited qualities, achieves through adaptation of himself to his environment, both social and material, and by the molding of his surroundings to the purposes of his own life. There may be as many ways of being healthy as of being sick. There is no one pattern for all persons, even for the two sexes, or certainly at all ages, for the achievement of individual health. It is an experience with life, not a static something to be had, held, given away, bought or sold.

Health is much more than the freedom or recovery from disease. It is a way of life, a balance, a compromise sometimes, worth sacrificing other desires or ambitions to achieve, and the most precious possession a person may lose or feel compelled to give up in exchange for other ambitions. The philosopher has said, "Give me health and a day and I will make the pomp of Emperors ridiculous." That is a quality of man the individual, not of that amorphous, helpless, blundering social entity, the Public.

What then does the public health department do if not give the public what it pays its taxes for?

As for the care of the sick we have the physician and the institution, so we find the family physician and the health department inseparably involved in an indispensable collaboration to the same end, that each person in the community may be spared avoidable handicaps of infection, nutrition, occupation, growth, development, personality, body and mind, and be so guided and guarded through the amazing experiences and complications of life among his fellows that

he wins his goal, whatever that may be for him, without violating the inexorable laws of human biology and so paying the penalty of ill health.

There are but six functions which modern civil government has found appropriate and necessary for a department of health. Whatever nation, state, city or rural area has created a department of health to be devoted to the application of the science of preventive medicine for social ends, it has found that vital statistics, communicable disease control, the hygiene of maternity, infancy and childhood, laboratory service, sanitation, and health education include all essential public health services. These are all auxiliary or supplementary activities, the benefit of which comes to the client or patient of the private practitioner. Each of these functions of a public health department is necessary to make more effective, not to supplant, the work of the family physician.

### Government Functions in Health Affairs

Think of these public functions in turn. Only government can require the reporting of births, deaths and their causes, and then analyze, interpret and publish them for the better understanding of the phenomena of living and dying, the facts of original record provided by the physician.

Only government can be trusted with the broad powers upon which communicable disease can be controlled. And yet at every point in the process of such control, be it by isolation of the sick, immunization of the susceptible or development of resistance against infection and establishment of full recovery from it, it is upon the family, the individual and their chosen physician that the actual service should and does fall.

For the hygiene of maternity, infancy and the child, if we had a consistently educated community of families, there would be no need for concern of the health officer with such matters. It was only because families and their physicians appeared a couple of decades ago unaware of the potential benefits of prenatal and infant care, of supervision of the pre-school and school child, that the health officer had to use his authority and the pulpit of his position to persuade people of the meaning, need and value of these, and lead the physician to a broader way of private practice by including them in his services.

To the obstetrician and pediatricist the Health Officer owes a particular gratitude for taking on his struggle before the medical profession. Certainly no public officer, elected or appointed, can be presumed to have such interest or responsibility for the health of the expectant mother as she herself and her husband should have, and should know enough to ask for from their physician. It is not that the care of the maternity patient, or the management of the infant, the examination of the runabout child or the direction of the way of life of the school child is an exclusive or wholly proper duty of the Department of Health, for it certainly is not, but the Health Officer must concern himself to see that every expectant mother knows what she ought to have in the way of guidance during her pregnancy and how this can be assured for her. It is not the function of a health department to become the community midwife, wet nurse or diaper expert, but by its persuasive and objective teaching it can bring it about that every mother and child receives such advice in the physiology of human development that growth may be uninterrupted and both mother and child may survive for their mutual advantage.

The necessity of a subdivision or bureau of the health department devoted to child hygiene and maternity is due to the age-old habit of people to think of the physician as a "sick doctor" to be called upon only when fear, or failure of home remedies, demands help. It ought to be as much taken for granted to call upon a physician to learn how to keep a baby or its mother well as to ask him to the home to diagnose a fever or set a broken bone.

#### Physiological Rather Than Pathological

The first basic science training which the medical student has is in physiology, the science of the functions of the normal human body, and upon this his understanding of abnormal function or disease is built. The Health Officer of a community is its hired teacher, obliged to advertise to the public the benefits to be expected from using the local practitioner as an expert in normal childhood, as well as calling on him for medicines or operations. For thirty years before there were divisions of health departments for child hygiene and maternity, the teachers and their textbooks at the medical schools dealt expansively with the

very methods of health management that are now the commonplaces of daily conferences in the private office, in the home, by doctor and public health nurse. But to reach the present still incomplete volume of use of this wisdom it has taken costly and patient repetition of advice, warning, persuasion, demonstration, actual services given free to mothers, and all the arts and pertinacity of the public health nurse, that university of health on wheels, the peripatetic teacher of family health, a very gadfly of good deeds.

As soon as the family practitioner and his patients have fully caught up with the hygienic ambitions of the health officer, and prenatal care is the rule and not the exception, and every infant has the benefit of medical supervision, then and only then can we do away with bureaus for maternity and childhood, as by that time the services will have been incorporated into the folkways of the people, and the oldest doctor will be proud of being called a physiologist, hygienist, and a health practitioner.

#### The Public Health Laboratory

For the public health laboratory we have but a word to say. Indispensable to the department of health for its necessary control of water, milk, foods, drugs, air, occupational hazards, etc., it serves everywhere today the highest and the most urgent needs of the practitioner of medicine as well. Whether for diagnosis or release of infection, relief from clinical uncertainty, to supply with exquisite appropriateness the immunizing or therapeutic substance, or to identify the infected or the insusceptible, the public health laboratory has raised the whole level of medical service to the sick and has vastly simplified the protection of the well. Even if under some circumstances clinical pathology can be well handled on a private laboratory basis there will always be epidemiological and control services which can be given only through such a public health agency as the laboratory of the state or city health department. The consultant position of the laboratory chief is one that could hardly be paid for at its true worth, and yet to the individual under his physician's care this costs little or nothing.

Sanitation need not concern us except to recall that environmental control, and protection of water and foods, are wholly outside the sphere of the medical practitioner.



The sanitary engineer and inspector are our professional collaborators upon whose integrity and acuteness we must wholly rely.

### Medicine's Most Valuable Mouthpiece

Health education, the sixth of the major functions of health departments, is medicine's most valuable mouthpiece. Decent regard for public opinion and the esteem of his fellows forbids the physician's shouting his wares from the housetops. He knows what the people need for their health and what he could do for them if they would come to him, but he must wait in modesty of manner, albeit eager and anxious in spirit, until the patient seeks his services. Not so the health officer. He has no reticence in his pack of tricks. Publicity is his leading suit. It is not himself he is advertising, but the possibility of better health to be had around the corner at a modest price, or, if necessary, without cost. This health education is one ceaseless repetition of well known truths in new terms and colors, until the particular fraction of the public affected responds. So-called health education is intended to create curiosity and then satisfy it, to develop a motive for action and facilitate the appropriate deed. What more perfectly adapted mechanism for encouraging all persons to go to their own physician to see if what they have heard from the health officer is all so. And that is right. Whatever is said by a public officer in the United States is suspected of being partial truth, extravagance, pure buncombe or politics. Don't do a thing you are advised to for your health, whatever the broadcast or salary of the health officer, until you have learned from your own physician whether it makes sense for you personally. But the health officer who has not taken the precaution to check his projected publicity on health with the wise heads of his local medical profession and get their prior endorsement is green on his job and riding for a fall.

In fact it ought to be the medical practitioners, familiar as they are with the needs for health teaching and service among their patients, who should formulate the substance and sequence of the public educational program, and press upon the health officer to do more and better teaching, and teaching that will bring about personal health of multitudes. Some optimistic people seem to expect public health to happen automatically

merely from general publicity and propaganda.

It would seem that with the possible exception in the undetermined future of the bureau of maternity and child health, and of parts of the program for communicable disease control, such as preclinical diagnostic tests and immunizations, the six standard functions of health departments are, and will remain, permanently indispensable, both to the public at large and to the members of families under private medical care.

### Private Physician and Preventive Medicine

What then shall be the full duty of the private physician in preventive medicine? Will he accept the constantly broadening scope of opportunities? Will he assume leadership and be the power behind the health department? Can he re-educate himself in the eugenic implications of his knowledge of hereditary family characteristics so that his word will be listened to with affection and respect in the matters of marriage and reproduction, as it has always been in questions of obvious and present disease and disability?

When I enjoyed a fifteen year status as a family physician I dreamed that some day I might qualify for admission to that choice company whom Stevenson once so beautifully characterized.

As Health Commissioner of New York City I received the complaints and heard the undoubtedly authentic evidence from the poor and the lowly, of neglected precautions for their health by their physicians. I wondered if I could keep my faith in the honor and integrity or scientific ability of my profession. As teacher of medical students I believe I see the truth, and can speak with sure confidence of the doctor of the near future. There is no finer product of our time than the men and women who are rapidly replacing us elders in medicine. They take for granted that they have knowledge, skill and the will to use it which will be sought voluntarily by persons of all walks of life for each of the three chief purposes of medicine, to care for the sick, to prevent disease, to create now and in those to follow, a greater probability of superior health.

The present day practitioner of medicine in his private relationship to his patients owes it to them and to himself to have a

plan of professional services which will include each appropriate resource of preventive medicine for whomsoever he may be called upon to advise. This is not the occasion to offer even a list of the contents of a personal practice of preventive medicine, but there are methods and fields of service so important and inclusive that I shall venture to list a few.

The whole practice of obstetrics and pediatrics, except for the management of surgical complications and intercurrent illness, is but an opportunity to apply physiology and wholesome psychology to reproduction, growth and development.

### Periodic Health Examinations

Without the use of the periodic health examination of adults, systematic protection against the handicaps of the later decades of life cannot be offered. Cancer, diabetes, heart and kidney diseases have all taught us how much can be expected by periodic medical evaluation of a person's health.

We cannot be honest with out science or our patients without the application of our resources to determine specific susceptibilities, to test the existence of certain infections, to render the individual resistant if not absolutely immune to smallpox, diphtheria, and in some areas typhoid, and to be prepared to use other active and passive immunizations for children as these prove reliable. Nutritional balance and the selection of diets appropriate to purse, work, and personal preference can hardly be attained without medical direction, at any period from cradle to old age.

Most difficult, least prepared for, uncertain of methods and results, is the gentle guidance of the spirit of adolescence into and through the urge to mate, to share true love, to mature into full responsibility and scope of an adult and balanced personality. Without intentional effort to participate in the protection of the mind, emotions and behavior by what is still so vaguely called mental hygiene, much of physical preventive medicine will be barren.

And lastly let me refer to the necessity of medical direction of the problems of fertility, sterility and eugenics, the decisions for or against perpetuating the qualities of potential parents, and the heavy social obligation of the medical profession to interpose, so far as personal liberty of patients permits, objections and effective obstructions

which will cut the threads of unworthy and deteriorating inheritance. As the Regius Professor of Physic in Cambridge, England, said in the last Galton lecture:

"If the doctor, who is already accepted as a servant, and, in some degree, as an instructor of the people, is enabled in course of time to state authoritatively that certain eugenic principles are not only sound but practicable, he will soon be given a hearing not only by his patients but also by statesmen—a hearing which non-medical eugenists, often far better informed but lacking the doctor's personal contacts and sphere of influence, have sought in vain."

Public health, compounded of private guidance of individuals and the social use of governmental services, means all these visions of human improvement. To bolster my own fond hopes with the opinions of those with wider experience and more responsibility let me quote from an influential committee report from Great Britain: "We regard it as of primary importance that the organization of the health services of the nation should be based upon the family as the normal unit and the family doctor as the normal medical attendant and guardian. It is not for disease that provision has to be made, but for persons liable to or suffering from disease. The first essential for the proper and efficient treatment of individual persons is therefore not institutional but personal service, such as can be rendered to people in their own homes, only by a family doctor who has the continual care of their health; to whom they will naturally turn for advice and help in all matters pertaining thereto; who will afford them such professional services as he can render personally; and who will make it his duty to see that they obtain full advantage of all the further auxiliary services that may be otherwise provided."

And I shall venture another quotation from an eminent Britisher, Sir George Newman, until recently and for many years the chief medical officer of the British Ministry of Health, in discussing governmental medical services for health, who gave his opinion of the contribution of the medical practitioner which applies equally to the situation in many, if not in all, parts of the United States today.

"The work of medical practitioners has not only saved life on a scale undreamt of a hundred years ago, but it has made living a better thing. Much of their teaching has now passed beyond the control of a profession and has entered into the common knowledge of mankind, forming, indeed, part of the very laws and customs of civilized nations.



It was the doctors who taught us the characteristics of a sanitary house, of the necessity for a pure and sufficient water supply, of the advantages of drainage, of the ingredients of a wholesome dietary, of the infectious nature of certain diseases, of the principles of personal hygiene—now all matters of common knowledge."

With these principles not only in mind but in current practice in this city of Detroit to a notable degree, and elsewhere in rural counties of this state, I believe it well for us to be alert to the interests of the public and our profession lest under the pressure of some governmental inclination to take sudden and unwise action we find ourselves hampered by the persuasive power of federal grants to undertake programs inconsistent with experience, and both untimely and immature.

What we need is more intelligence, some patience, and much good-will to bring the full benefits of preventive medicine to our people, more than money borrowed from the future. Errors of economic theory and practice can easily so shackle us and our successors that relief from some of the still lingering preventable diseases will seem to be but small return for our accumulated indebtedness.

There are two great Michiganders to

whom in closing I wish to pay my respects, men of medicine whose vision, courage and resourcefulness made a notable record of wise public action for health in this state, and influenced the progress of preventive medicine far and wide. I refer, of course, to Drs. Henry B. Baker and Victor Vaughan. These men saw in their day, as their successors in private and public life do today, that the full value of the well established facts of preventive medicine depend upon an alert and informed laity, a competent body of private practitioners of medicine in all its stages, and public service for health which will do for the community what the individual physician cannot do alone for the public as a whole.

As in fact most if not all the original contributions to the science and practice of preventive medicine have come from the hand of the general practitioner of medicine and from the laboratories of our institutions of higher education, so the universal application of organized services for the betterment of human health will be built, as we now see it developing, upon the services sought from and provided by the family physician, supplemented and greatly reinforced by the indispensable services of the local and state departments of health.

## THE USE OF CRYSTALLINE INSULIN IN THE TREATMENT OF PATIENTS WITH SEVERE DIABETES\*

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and

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During the past two years we have had the opportunity of using crystalline insulin (Stearns) in the treatment of 150 diabetic patients. We first became interested in this product on account of its purity. Our earliest studies<sup>3</sup> revealed that crystalline insulin has a slow action and a prolonged effect on the blood sugar, and that in the treatment of diabetes mellitus the blood sugar levels could be better controlled with fewer doses and with fewer total units than was possible with unmodified (regular) insulin. These observations have been corroborated by Freund and Adler,<sup>6</sup> Mains and McMullen,<sup>7</sup> Barach,<sup>4</sup> Allen,<sup>1</sup> and most recently by Shephardson and Friedlander.<sup>10</sup>

Crystalline insulin was then tried in the treatment of diabetes mellitus associated

with various complications,<sup>2</sup> in patients ranging from six to eighty-six years of age. After a year's experience with 100 patients, sixty-one of whom manifested some type of complication or associated condition, it was found that this insulin could be used successfully in any type of diabetes requir-

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## CRYSTALLINE INSULIN—ALTSHULER AND LEISER

TABLE I. PATIENTS REQUIRING 20 UNITS OR MORE

Age Group	One Dose	Two Doses	Total	Total Patients in the Age Group
1-15	1	3	3	5
16-30	0	17	17	19
31-45	1	17	18	19
46-60	11	31	42	67
Over 60	0	18	18	40
Totals	12	86	98	150

TABLE II. PATIENTS PRESENTING SPECIAL PROBLEMS

Age Group	Insulin Sensitive	Complications	Total Patients in the Age Group
1-15	4	1	5
16-30	11	6	19
31-45	5	9	19
46-60	5	46	67
Over 60	1	30	40
Totals	26	92	150

ing insulin, with the possible exception of diabetic coma, in which condition it was not tried.

Since that time special attention has been given to the study of patients with severe diabetes, and the present report is based upon experiences with crystalline insulin in such patients, some of whom have been using this preparation continually for two years. For purposes of this study, severe diabetes is considered to include one or more of the following criteria: (1) The patient requires more than twenty units of insulin daily; (2) the patient is the labile insulin-sensitive type; or (3) the patient has an associated complication.

The first group is merely an arbitrary standard for consideration here (Table I). There were ninety-eight patients in this group, of whom eighty-six required two doses of insulin daily while twelve were able to get along with one dose daily.

The second group, comprising the insulin-sensitive patients, has always been the most difficult to keep under constant control (Table II). The third group is included because the mildest diabetic patient who develops a complication, such as an infection or gangrene, becomes a severe diabetic from the standpoint of treatment. It is interesting to observe that of the 26 insulin-sensitive patients by far the greater number occur in the early age groups and in fact comprise a very large percentile part of these groups, whereas the patients with complications make up the greater part of the late age groups. Table III presents the types of complications and associated conditions which were encountered. Some of these patients were treated in the hospital as in-patients, some were treated in the clinic as out-patients, and the rest were private patients seen in the office. All of these patients were well controlled with crystalline insulin, the criteria of diabetes control be-

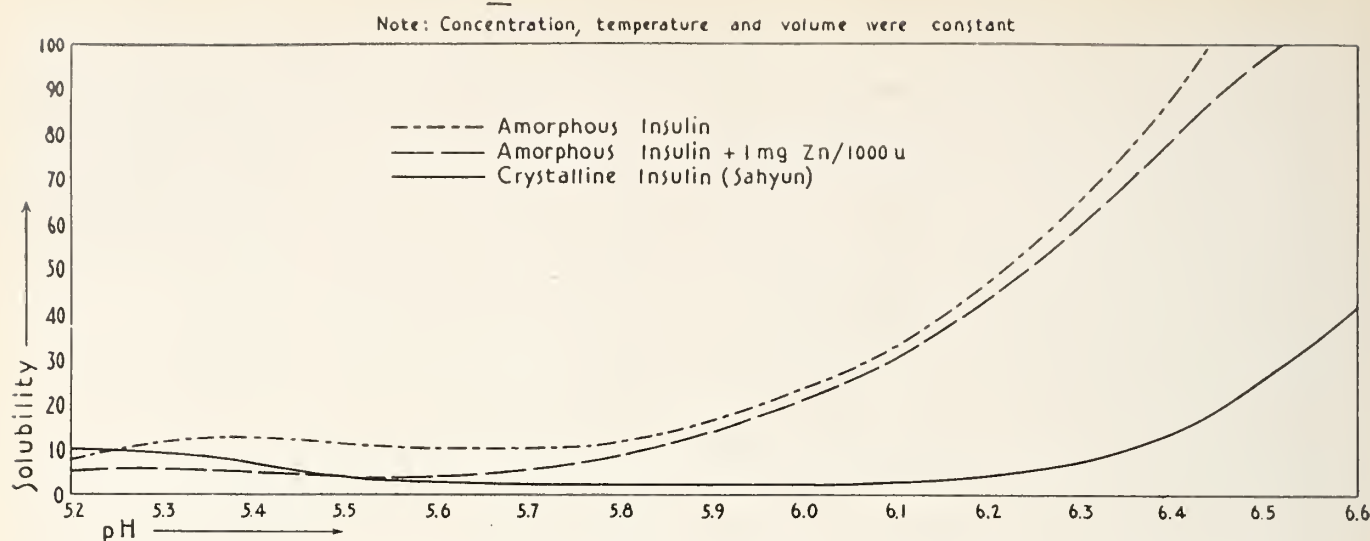
TABLE III. TYPES OF COMPLICATIONS

<i>Infections</i>	<i>Cardiovascular</i>
Respiratory	Hypertension
Syphilis	Cerebral hemorrhage
Tuberculosis	Cerebral thrombosis with hemiplegia
Osteomyelitis	Coronary thrombosis
Ulcers of leg	Heart disease
Carbuncles	Hypertensive
Infected wound	Arteriosclerotic
<i>Eyes</i>	Rheumatic
Cataracts	Paroxysmal auricular fibrillation
Acute iritis	<i>Peripheral vascular</i>
Neuroretinitis with blindness	Gangrene
<i>Endocrine</i>	Buerger's disease
Hypopituitary	<i>Skin</i>
Amenorrhea	Psoriasis
Pituitary dysfunction	Squamous cell epithelioma
Hyperthyroidism	<i>Genito-urinary</i>
<i>Gastro-intestinal and Biliary</i>	Orchitis
Peptic ulcer	Prostatitis
Catarrhal jaundice	Uremia
Cholecystitis	<i>Other complications</i>
<i>Neurological</i>	Fracture
Diabetic neuritis	Asthma
Epilepsy	Arthritis
Parkinson's disease	Pregnancy
Neurosyphilis	Pre-operative and post-operative
Ophthalmoplegia	Acidosis
Senile dementia	
Psychosis	

ing (1) aglycosuria throughout the twenty-four hours, and (2) blood sugar levels between 70 and 180 mg. per 100 c.c. The blood sugar levels between 120 and 180 mg. per 100 c.c. are apparently better tolerated by patients with severe cardiovascular disease than the lower ranges. Blood sugar studies were made at periodic intervals throughout the twenty-four hours, usually at 5 and 10 A. M., 3 and 7 P. M. and at 12 o'clock midnight. A fasting blood sugar alone is insufficient evidence of the true range of blood sugar level throughout the twenty-four hours.

Crystalline insulin is administered subcutaneously in one or two doses daily. The morning dose is given one-half to one hour before breakfast, and the second dose, if it is necessary, is given about ten to fourteen hours later, either before or after the





SOLUBILITY OF CRYSTALLINE, AMORPHOUS (UNMODIFIED) AND AMORPHOUS + ZINC (1 MG. PER 1,000 UNITS)

Chart 1. Crystalline insulin and amorphous insulins do not yield the same solubility curves on the alkaline side of their respective isoelectric points. Crystalline insulin is less soluble than amorphous insulin with or without added zinc at acidities ranging from pH 6.0 to pH 6.6. (This chart reproduced through courtesy of Dr. Sahyun.)

evening meal. The change from unmodified to crystalline insulin is very easily accomplished. The patient is started on 75 per cent of the total units previously taken, divided into two doses. Each dose is subsequently adjusted according to fractional urine examinations. For a patient who has never taken insulin and who does not have any complications it has been found best to start with an arbitrary amount of from 20 to 30 units divided into two doses and to adjust each dose as indicated. Should the patient have an infection or an acidosis, the starting amount must be somewhat larger—40 to 50 units, divided into two doses. It seems obvious that prolonged-acting insulins are not suitable for the treatment of diabetic coma because this condition is a medical emergency and requires the most rapid-acting insulin available.

In arranging diets for patients using crystalline insulin the total available glucose is divided into three equal parts. In 5 to 10 per cent of the patients—usually those in the insulin-sensitive group—it has been necessary to give an additional 100 to 200 grams of milk four hours after the evening meal.

With crystalline insulin, local reactions have been very rare even among those patients who manifested marked reactions to other insulins. Meyers<sup>8</sup> reports a patient who was reacting with giant hives to unmodified insulin but who has been able to take relatively large doses of crystalline insulin without any local reaction. In our

group there were several patients with lipodystrophy at the site of unmodified insulin injections. The use of crystalline insulin by these patients for two years has not produced these atrophic deformities of arms or thighs.

General allergic reactions with diffuse urticaria occasionally occur with the use of unmodified insulin. Foster<sup>5</sup> reports the case of a diabetic patient who was in acidosis and to whom it was consequently necessary to give large doses of insulin. The administration of unmodified insulin caused a severe generalized urticaria, and the intravenous administration of this insulin brought about severe allergic shock which necessitated adrenalin for relief. With all this, the patient seemed to be refractory to unmodified insulin; the acidosis was not relieved and the CO<sub>2</sub> combining power went down to 10 per cent. The patient was then given large doses of crystalline insulin, which relieved the acidosis and did not bring forth any allergic reaction.

The incidence of hypoglycemic reaction has been less with crystalline than with unmodified insulin, and these reactions, when they did occur, were not associated with as severe shock. Hypoglycemic reactions due to crystalline insulin are relieved by the administration of one teaspoonful of Karo syrup or sugar with one-half glass of milk. This is repeated in 15 minutes if necessary, and if the symptoms have not abated within half an hour 50 per cent glucose is given intravenously. Milk is given with the sugar

in these reactions because of its protein content which takes care of the prolonged action of the insulin. The time when an insulin reaction may occur is definitely predictable because the duration of action of crystalline insulin is constant in a given patient, and the potency does not vary.

I am indebted to Dr. Sahyun,<sup>9</sup> for the following chemical data and the explanation of the mechanism of prolonged hypoglycemic effect of crystalline insulin:

"The crystalline insulin which has been used in this study has a zinc content of not more than 0.04 mg. per 100 units, a nitrogen content of approximately 15 per cent, and ash of approximately 1.5 per cent or less; it has been found to assay  $22 \pm$  units per mg. This insulin is remarkably stable, having been kept at a temperature of 40° C. for 16 months without any loss of potency.

"Chart I shows the comparative solubility of unmodified, or amorphous insulin, and crystalline insulin at the various pH levels. Crystalline insulin is less soluble than amorphous insulin at acidities ranging from pH 6.0 to pH 6.6. At about pH 6.6 amorphous insulin is entirely soluble, whereas crystalline insulin is not completely soluble. This is of practical importance because the pH of insulin when it is injected is about 3.0 and the body fluids must change it to the pH of the body tissues (7.4) before it can be absorbed. Thus the diminished solubility of crystalline insulin explains its slower absorption and prolonged effect."

As we mentioned in a previous report<sup>2</sup> there is evidence of a possible hyperglycemic principle in amorphous insulin which is removed in the process of crystallization; this may be another factor in the explanation of the increased efficiency of crystalline insulin.

In conclusion I should like to summarize the points which seem to me most cogent:

1. Severe diabetes can be well controlled by the use of one or two doses of crystalline insulin daily.

2. The treatment of diabetes with crystalline insulin is very simple, requiring no unusual arrangement of the diet or insulin dosage. The change from unmodified to crystalline insulin can be very easily accomplished.

3. Because of the purity of the product this insulin is particularly suitable for the use of persons subject to allergic manifestations.

4. Because the action of this insulin is uniform and constant, and therefore predictable, hypoglycemic reactions can be avoided.

We are indebted to Frederick Stearns and Company for the generous supply of crystalline insulin used in this study.

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## AMAUROTIC FAMILY IDIOCY (TAY-SACHS DISEASE)

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In 1937, in this JOURNAL, Cooperstock<sup>1</sup> reported a case of this disease in a Gentile infant. Previous to his study, there had been only fifteen cases ever reported in non-Jewish children, and only three of that number had been examined postmortem. The early recorded observations of amaurotic (*ἀμαυροσίνη* = to darken, blindness) idiocy gave the impression that the disease was distinctly familial and confined to Jews, especially Polish Jews, but later reports have shown that "it is not rare in Hebrews of other nations, and may occur in non-Jews."<sup>5</sup>

From the first three to nine months of life, the infant is apparently normal. Then it begins to show a general weakness, is unable to move its extremities properly or hold

up the head, and finally, even with support, is no longer able to sit up. About the time that the weakness makes its appearance, the vision begins to fail and the baby becomes



sensitive to sound and touch (hyperacusis). Even the slightest stimulus may be sufficient to throw the child into a position of decerebrate rigidity or generalized convulsions.

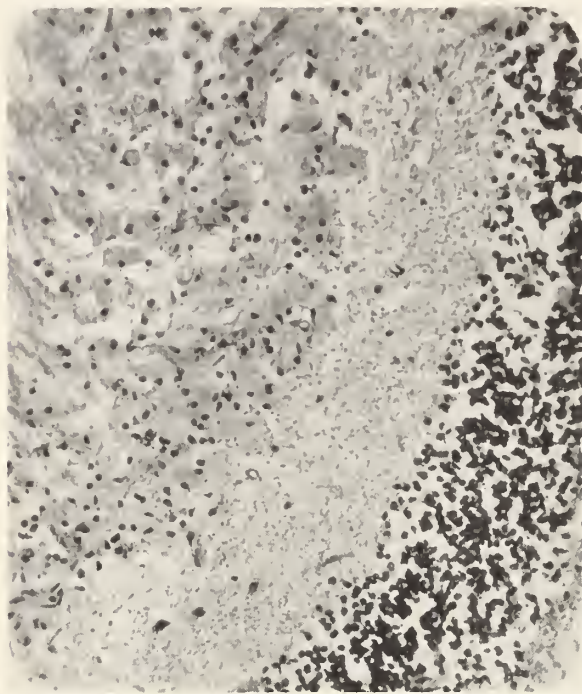


Fig. 1. Retina showing ballooning of ganglion cells. Hematoxylin and eosin stain.  $\times 250$ .

At first, the muscles are soft and flabby and later in the illness may show atrophy. The tendon reflexes are absent or diminished, but it is said that they may be normal or exaggerated. The ophthalmoscopic examination will show the characteristic cherry-red spot, surrounded by a white halo, in the macular region, and there is always a concomitant optic atrophy. As the blindness increases, the pupils become dilated and fixed to light. Occasionally, there is nystagmus and extraocular palsies.

As the general weakness increases and the blindness progresses, the child fails mentally. It is no longer able to say simple words, play with toys, nor show any interest in its surroundings. The course of the disease is such that the child finally becomes a vegetating idiot and dies of general weakness or some intercurrent infection before the end of the second year.

Because amaurotic family idiocy is one of the few diseases of the brain to show specific ganglion cell changes and because these changes are so striking, much attention has been given to the study of the pathology after fixation and staining. The usual methods of fixation limit the study of lipoid, or

fat-like, substances. Unfortunately, we too began our study after fixation with formalin, so we can add nothing as to the true nature of the fat-like material. Our observations of the eye help to substantiate the explanation of Pointon, Parsons, Holmes,<sup>4</sup> and Hassin,<sup>3</sup> as to the cause of the cherry-red spot, and our notes on therapy may be of value in further study of treatment.

### Case Report

A baby girl was first seen on April 14, 1937, at the age of sixteen months. A study of the family history on each side for three generations did not reveal any similar case. The parents were of American extraction and there was no consanguinity. The patient was a full-term baby, weighing eight pounds, and the mother was well all during the pregnancy. At the age of two and one-half months, the child had pneumonia followed by full recovery. When six months of age, she could say single words, such as "Mama," "Dada," and "Oh Boy." At nine months, she could sit up. Soon after this time, the child's weakness became apparent as she could no longer sit up without support, and, at one year of age, she was unable to hold her head erect. Though the parents believed the child did not see well, they did not have a medical examination until she began to have convulsive seizures at the age of sixteen months.

*Examination.*—The child was held by the mother as she was unable to sit alone or hold up her head without support. The muscles felt soft and there was a complete absence of all deep reflexes. An examination of the fundi showed a bilateral white optic disc and a cherry-red spot, surrounded by a large white halo, in the macular region of each eye. Sensitiveness to sound (hyperacusis) was especially marked as the slightest noise would cause the child to start suddenly. The spleen and the liver could not be palpated.

*Roentgen Ray Findings.*—Chest studies were normal. Skull: The anterior fontanelle was rather large and was not closed. The forearms, legs, and pelvis showed a slight amount of rickets to be present.

*Laboratory Findings.*—Red count: 4,830,000; hemoglobin, 13.7 grams; white count, 7,550. Differential count: Polymorphonuclears, 48; lymphocytes, 50; basophiles, 20; polymorphonuclears, filamented, 27 and nonfilamented, 21. Blood Kahn tests on both mother and child were negative. Blood sugar was 52 milligrams; blood calcium, 10 milligrams; blood phosphorus, 2.8 milligrams. Splenic puncture findings: Although there was no spleen nor liver enlargement clinically, a splenic puncture was performed by Dr. Donald Chandler and the material was examined by Dr. W. P. L. McBride, who, after study by the usual staining methods, considered the spleen to be normal.

*Treatment.*—The treatment to the present time has been purely symptomatic and, as endocrine preparations have been used by others without success, we decided to use vitamins although there was no definite indication for such therapy. From April 21, 1937, until August 2, 1937, the infant was given Natola (Parke Davis and Company), ten-drop doses twice each day, for its vitamin A and D content, and vitamin B extract, or "complex," as it is sometimes called (Parke Davis and Company), one teaspoonful twice each day. The vitamin administration had no effect on the course of the disease.



*Course.*—During the next few months, she became weaker and had more frequent convulsions. Various stimuli, such as a loud sound or a sudden jarring of the bed, would cause a convulsion. At other times, she would become rigid all over for a few moments without any convulsive movements.

The appearance of the cherry-red spots did not change, but the optic discs became entirely white, the pupils dilated and fixed, and, for the last two months of her life, she had a horizontal nystagmus.

In the first week in June, she began to have difficulty in swallowing and developed a stridulous breathing. She became gradually weaker and died on August 12, 1937.

Postmortem studies were made by Doctor William M. German. There were no abnormalities of the external surface of the body nor of the internal organs. Normal cellular architecture of the spleen and the liver was not disturbed and there were no fats within the cells.

The external configuration of the brain was normal. On microscopic examination, the ganglion cells of the cortex of the cerebrum and the cerebellum presented the usual changes found in amaurotic idiocy; that is, the cytoplasm was ballooned greatly, the nucleus was eccentric and in many cells it had disappeared. The Nissl bodies were either absent or crowded to one pole of the cell.

The ganglion cells in the retina of each eye presented the same changes as the cortical cells of the central nervous system (Fig. 1). In the retina, the greatest number of ganglion cells is found in the region of the macula and their destruction and swelling is the cause of the white halo. The cherry-red spot is due to the normal red color of the fovea centralis, which is practically devoid of ganglion cells and therefore does not undergo the changes that

are seen in the cells in the remainder of the retina.

It was not possible to stain the fat-like material in the ganglion cells of either the brain or the retina with osmic acid.

Except for a slight increase in the number of glia cells, there was no marked change in the white matter of either the cerebrum or cerebellum.<sup>2</sup>

### Comment

This report of a case of infantile amaurotic family idiocy in a Gentile brings the total number of such cases reported to seventeen and the number of autopsy descriptions to four. Although we were unable to add anything new concerning the pathology, we hope that our observation will stimulate others to study fresh material before it has been placed in formalin. In this way, someone may come nearer a solution of the question as to the nature of fat-like substances in the degenerated ganglion cells.

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## ELECTRENCEPHALOGRAPHY: INTRODUCTION AND PRESENT STATUS\*

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The electrencephalograph is in its essentials a machine similar to the electrocardiograph although by use of modern audio-amplifiers a greater sensitivity to small voltage fluctuations is achieved. The apparatus is designed for amplifying and recording the small oscillating changes of voltage that can be led from the surface of the human scalp. Berger, in 1929, started a description of the records in normal and abnormal individuals which he has continued up to the present time. His energetic work has given a new impetus to the medical application of an old line of research that began in 1874. His genius has also offered us many clues to the significance of these phenomena.

A suitable type of active electrode and one which we are using at the present time consists of a small flat lump of solder, five millimeters in diameter, applied to any place on the scalp that has just been cleansed of its oily film by acetone. The hair need not be removed. A small dab of electrocardio-

graph paste between the solder lump or electrode and the scalp keeps the skin resistance at a low value (2,000 to 10,000 ohms). A coat of six per cent collodion that has dried thoroughly will hold the electrode in place and will keep the electrode paste from drying. The solder lumps are connected to the leads of the amplifying apparatus by a short length of fine enameled copper wire. Davis<sup>12</sup> proposed, as a standard procedure, that a similar lead on the

\*The apparatus for this work in electrencephalography was supplied by Wayne University, College of Medicine, while the facilities for the pursuit of this research were granted at Harper Hospital through the courtesy of Dr. Hugo A. Freund.



ear or the skin over the mastoid process will act as an indifferent electrode to which the activity picked up by the electrode on the scalp can be compared.

Differences in voltage occurring between the electrodes on the scalp and on the ear are normally between 20 and 100 microvolts. With the use of a shielded audio-amplifier that will not distort the form of these voltage changes in either the time or voltage scale, these differences of potential can be amplified to a magnitude that will activate an accurate although relatively insensitive recorder. We have in use a capacity coupled, push-pull amplifier built by Albert Grass of Quincy, Massachusetts, which is capable of about one million-fold voltage amplification and has an overall time constant of about 0.1 second. For a recorder we use an ink-writer capable of transmitting frequencies up to 80 cycles per second without distortion. It delivers on moving paper tape a permanent record of voltage change with time. Fortunately for clinical work such modern recorders produce an easily readable record during the examination of a subject so that a preliminary interpretation is possible at once.

With more than one amplifying and recording unit several places on the head can be studied and compared simultaneously. This is often important in determining the point on the scalp which is first to show an abnormal pattern. Such an area may then be considered as the origin of the disturbance.

The standard electrencephalogram is taken under a particular set of conditions originally used by Berger<sup>4</sup> and recently emphasized by Davis.<sup>12</sup> The subject should be as comfortable as possible and in a state of physical and mental relaxation. The eyes must be closed to exclude visual stimulation. Extraneous sounds should be at a minimum. The patient should feel at ease and secure but must not be drowsy. We have a sound-proof, light-proof and electrically shielded room with adequate ventilation in which the patient lies on a hospital bed. All amplifying and recording units are operated outside of this room. It is often necessary to leave the door to this room ajar in order to assure a feeling of safety to our younger patients. In this case the eyes are kept closed. In some badly disturbed cases it is necessary to have an observer in the room.

In a state of quiet repose a record obtained from a pair of electrodes, one on the occiput and one on the ear, is dominated by a wave of 10 cycles per second in most normal individuals. These waves are usually found in trains or groups; the average voltage of these waves varying from 20 to 100 microvolts. The interruptions in the rhythm that result in the groupings are relatively frequent, may be rhythmical and may last for long or short periods depending upon some characteristic of the individual at present unknown. This 10 per second rhythm is the alpha or Berger rhythm (alpha rhythm preferred). The frequency in different subjects normally varies from eight to 13 cycles per second but the frequency is surprisingly constant in any one subject from day to day (Loomis, Harvey and Hobart,<sup>33</sup> Travis and Gottlob<sup>36</sup>). The extent of the alpha rhythm has been expressed by Davis<sup>12</sup> as a percentage. This is obtained by dividing the total number of alpha waves possible in at least one-half minute of record by the actual number of alpha waves recorded during that period. The only alpha waves counted are seven microvolts or more in amplitude and in groups of three or more waves. This percentage of alpha rhythm varies from less than 10 to more than 90 in normal subjects.

There is a characteristic localization of this alpha rhythm to a band roughly two inches broad across the occiput of the head above the inion and extending laterally for two inches to either side of the midline. As the active electrode is moved away from this band the amplitude and the percentage of the alpha rhythm generally decreases (Adrian and Yamigima<sup>3</sup>). However, alpha waves can be recorded from any point on the surface of the scalp indicating that all parts of the cortex can function similarly to produce 10 per second waves (Jasper and Andrews<sup>27</sup>).

To complicate matters, other waves of different frequencies are also present although they do not dominate the record unless there is a low percentage of alpha rhythm. When alpha waves are present these other frequencies are superimposed. One of these frequency bands has been designated as "beta" waves and has an average frequency of 26 cycles per second with a range of 20 to 50 cycles per second (Berger<sup>4</sup>). Their voltage is usually 10 to 20 microvolts. Recently Grass and Gibbs<sup>22</sup>



have called attention to another frequency of 18 per second which is normally present but which cannot be evaluated with present data. Figure 1 illustrates typical records from occiput and vertex leads.

Many investigators have offered proof that these potentials are from the cerebral cortex. Records taken with leads on the skull, on the dura and on the pia of a human at operation are changed only in amplitude. These facts indicate that these structures act only as a shunt or short-circuiting system when records are taken from the scalp (Foerster and Altenburger<sup>18</sup>). These structures, therefore, do not appreciably distort the pattern. No smooth frequency in the neighborhood of 10 per second with 20 to 100 microvolt magnitude has been encountered in the white matter of the nervous systems of either experimental animals or humans (Berger<sup>6</sup>). The human electrencephalogram shows no relation to the electrocardiogram, respiration or normal variations of the peripheral circulation (Berger<sup>4</sup>). To make even more conclusive the cortical origin of these phenomena, Kornmüller<sup>28</sup> brought forth evidence that in animals the potential pattern varies with the cyto-architectonics of the cortex under the active lead. We can only conclude from these and many other experiments that the site of origin of the electrencephalogram is the grey matter of the brain.

Action potentials from the skeletal muscles of the head and face can be found in the electrencephalogram but they are sharply differentiated by a spiky appearance, irregular frequency and a very short wave length (Adrian and Matthews<sup>2</sup>). With care these artefacts as well as those which arise from the movement of the head and eyelids can be abolished even during a convulsion.

Perhaps the most striking effect upon the alpha rhythm in normal individuals is the marked depression of amplitude that occurs with visual stimulation (Berger,<sup>5</sup> Fig. 1). In most subjects opening the eyes even in dim light causes almost complete suppression of the alpha rhythm. The rhythm returns, however, as soon as the eyes are closed or may gradually return with the eyes open during the next 15 to 20 minutes. The latter process is facilitated by a visual field that has no pattern and is evenly illuminated. A complex mathematical problem, during its solution, will also suppress

the alpha rhythm. In fact, Berger<sup>7</sup> has suggested a close correlation of the suppression of the alpha rhythm with the focusing of attention rather than with any spe-

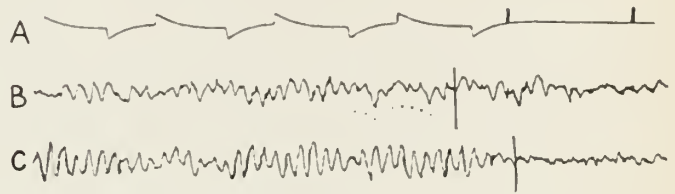


Fig. 1.: E.E.G., No. 41, normal.

*Record A:* 20 microvolt calibration signal. Negativity of active electrode on scalp relative to the ear lead produces an upward deflection. One second interval between the two vertical marks. Read from left to right.

*Record B:* Active electrode on left vertex and indifferent electrode on left ear. Normal person. Note the presence of a high percentage of alpha waves with beta waves superimposed. The vertical line is at the approximate time a command was given to open eyes. The flattened record at the right hand end of the tracing is typical of the suppression of the alpha rhythm by visual stimulation. The latency in these records of this suppression is entirely dependent upon the reaction time of the experimenter and the subject and is therefore extremely unreliable.

*Record C:* Active electrode on left occiput and indifferent lead on left ear. Same subject as in B. Note the higher voltage of the alpha rhythm, its modulated amplitude and the more striking suppression of the alpha rhythm with opening of the eyes after the signal. The same errors in the signal apply as in record B.

The records are from a young woman who has a rather nervous temperament and who has a long standing duodenal ulcer. The nervousness is reflected in the brain waves by some of the occasional slow waves seen from the vertex lead (record B). They are indicated by the faint dots under the record. There was no question of drowsiness at the time of these records.

cial type of stimulus. Davis, Davis and Thompson<sup>14</sup> and Hoagland<sup>26</sup> have implied in their writings that an emotional factor in each stimulus may also play a part in suppressing the alpha rhythm.

According to Berger<sup>8</sup> there are no alpha waves at birth. In addition, Berger,<sup>8</sup> Lindsley<sup>32</sup> and Smith<sup>35</sup> have described the presence of slow irregular waves of four per second in infants and the development of more rapid and regular waves (seven to eight per second) with advancing years until at the age of ten to twelve the alpha rhythm of the adult state is obtained.

At present the most acceptable explanation for the origin of the alpha rhythm is that groups of nerve cells in the grey matter of the cerebral cortex change their voltage in unison relative to some neutral point such as the lobe of the ear. Presumably



some pacemaker, as in the heart, keeps the activity of the group of cells synchronized. When disturbed by a pattern of afferent stimulation then the degree of synchroniza-

age. A new wave appears at a frequency of two to four per second (Loomis, et al,<sup>3,4</sup> Blake and Gerard,<sup>9</sup> Davis, et al<sup>13,14</sup>). The alpha waves finally disappear and two to

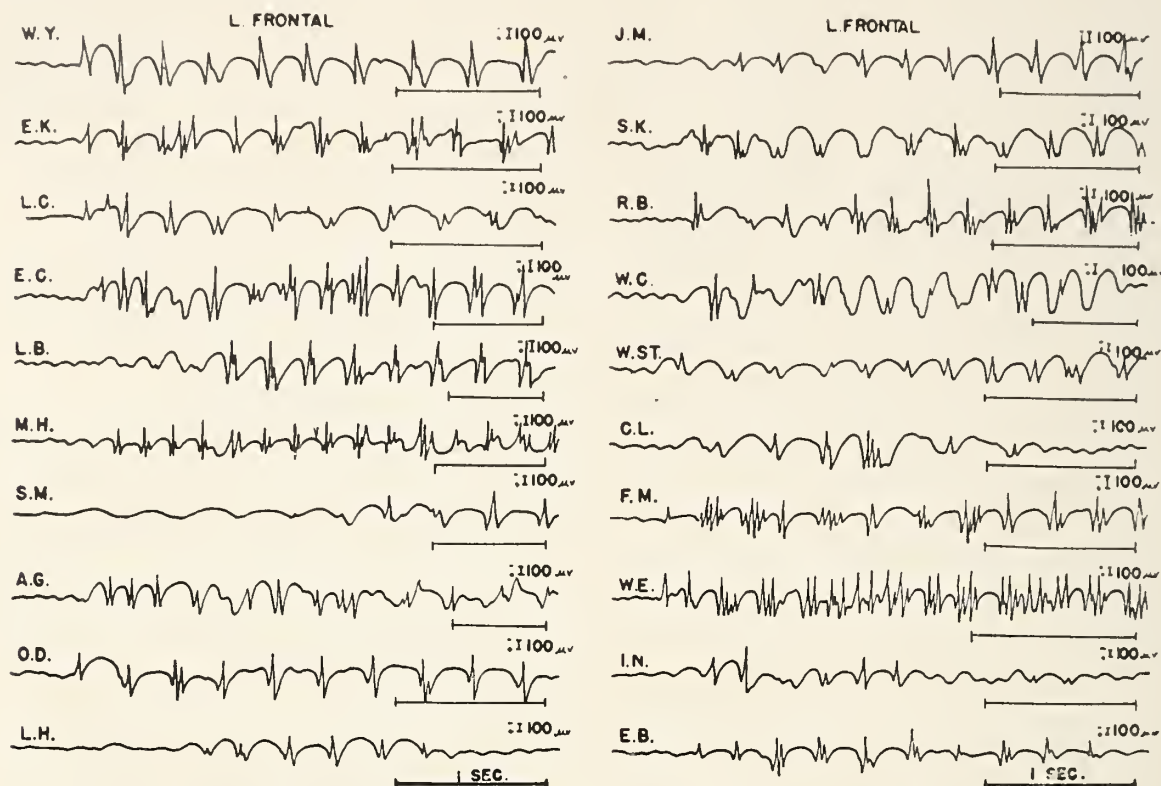


Fig. 2.: Re-photographed from Figure 1, in article of Gibbs, et al, 1936. The following is their legend to this figure:

"Seizure patterns from twenty patients with petit mal epilepsy. All the records show the activity of the left frontal area. Wave and spike formations are obvious in all cases. The duration of the wave and spike formation tends to be about one-third of a second, though it is faster at the start of the seizure and slower at the end. The relatively flat tracing at the left of each record is the patient's normal record. These records were made with one lead to the lobe of the ear and the other to the area designated, the electrode to the ear being connected to the ground of a capacity-coupled amplifier and the other to the grid. The recording instrument was in each case an ink-writing galvanometer. In all records an upward deflection indicates that the electrode connected to the grid was negative with respect to the ear. The calibration in microvolts is given at the end of the record. The horizontal line in the lower right corner marks the duration of one second."

tion is markedly lessened. This is exemplified by the suppression of the alpha rhythm when the eyes are opened or when solving a problem (Adrian,<sup>1,2</sup> Hoagland<sup>23</sup>).

We introduce our description of the changes wrought in the electroencephalogram by pathology with a discussion of the effects of sleep. The pattern of the brain waves during sleep bridges the gap between a normal and an abnormal record. At the onset of sleepiness the alpha rhythm increases in percentage in all subjects until a well established rhythm is present. Shortly after this the alpha waves are broken by pauses of a second or more. At the end of these intervals normal subjects will signal that they have experienced a sensation of "floating." These pauses increase in length and the alpha waves decrease in volt-

age. A new wave appears at a frequency of two to four per second (Loomis, et al,<sup>3,4</sup> Blake and Gerard,<sup>9</sup> Davis, et al<sup>13,14</sup>). The alpha waves finally disappear and two to

four per second waves with spindles of twelve to fourteen per second waves superimposed take the place of the normal record. This pattern is replaced in deep sleep by irregular waves of one to three per second. Anoxia, on the other hand, while it produces changes that are similar to those of sleep, can be distinguished by the brain wave pattern. Anoxia shows even more clearly the patterns of abnormal activity of the brain. Breathing eight per cent oxygen mixtures produces a slowing of the alpha rhythm to six to eight per second along with the appearance of the slow two to four per second waves. Continuation of anoxia results in the loss of the alpha waves and finally a complete flattening of even the slow waves, at which time the subject's con-

dition is critical. In both sleep and anoxia the presence of slow waves is coincident with a marked impairment of consciousness (Davis, et al<sup>13,14</sup>). We may, therefore, conclude that states of depression leading to unconsciousness are associated with the waves of slower frequency (Gibbs<sup>19</sup>). This is checked by the experiments on brain waves with many anesthetics (Adrian and Matthews;<sup>1</sup> Derbyshire;<sup>16</sup> Lennox<sup>31</sup>). Insulin shock also produces many of these very slow one to four per second waves (Hoagland<sup>24,25</sup>).

The electroencephalogram has been clinically useful in two particular conditions since its development in 1929. The first of these is epilepsy. Gibbs and his collaborators have described three types of brain waves associated with different types of epileptiform discharges (Gibbs, et al<sup>19,20,21</sup>). The following two examples are well known clinically. In grand mal attacks there is a high voltage beta wave recordable over the entire surface of the scalp. This discharge is very similar to that produced in animals by convulsants such as strychnine (Dusser de Barenne<sup>17</sup>). Petit mal attacks on the other hand are associated with a combination of beta and slow waves. These patterns are almost individually characteristic in their exact makeup but they all follow the general plan illustrated in Figure 2 of a slow wave with a spike that has the frequency of a beta wave superimposed. These facts are hardly as practical a point, however, as the observation that slow waves may appear in groups during the record of these petit mal epileptics between seizures. These periods indicate the presence of larval seizures which are not accompanied by any clinical or subjective manifestation. These larval seizures also allow localization by the electroencephalogram of the origin of the epileptiform discharges while the patient is quiet. It is common to find these peculiar larval seizure waves originating in only one area of the cortex and spreading generally through the cerebrum only at the time of convulsion.

The second clinical use of the electroencephalogram which is being rapidly developed is the localization of many forms of cerebral lesions. Walter<sup>37,38</sup> particularly has advanced this phase of the work. He described the localization of tumors by finding a localized focus of slow waves which he called "delta" waves with a frequency of

one to four per second (Fig. 3). The electroencephalogram will, however, only show localization of a delta focus after any high intracranial pressure that was present has



Fig. 3.: E.E.G., No. 7-A:

Typical slow or delta waves from an area near a brain tumor.

*Record A:* Calibration of 50 microvolts with a filter in the circuit which cuts down the amplitude of all frequencies faster than 30 per second. This produces the rounded tops on the calibration deflections. Negativity of the active lead on the scalp is downward in the record. Read from left to right. The vertical marks indicate a one second interval.

*Record B:* Record from an 11-year-old patient with a very large cerebral tumor proven at operation. Active lead on the right vertex with indifferent electrode on the right ear. The most obvious phenomenon is the delta wave at a frequency of two to three per second. These waves indicate a depression of cortical function in this area.

been removed. Walter<sup>38</sup> has clearly indicated that high intracranial pressure in itself will produce delta waves detectable from the entire scalp. Forster and Altenberger<sup>18</sup> state that the center of a tumor is less active than the surrounding areas and that presumably the delta waves arise from the depressed tissue immediately surrounding the tumor. Recently the signs in the electroencephalogram of cerebral lesions have been added to by Case and Bucy<sup>11</sup> to include: (1) regular delta waves, one-half to three per second; (2) very slow waves from one to two in five seconds; (3) sharp sudden spikes, particularly in groups; (4) patterns characteristic of convulsive seizures, and (5) loss of alpha rhythm on one side. Besides these, Lemere and Yeager and Bolles<sup>39</sup> include: (1) the presence of a strong alpha rhythm that is not affected by visual stimulation; (2) differences in amplitude of the alpha rhythm on the two sides. At present the complete data are insufficient for a description of the brain wave pattern as related to the position or type of the lesion in the cranial cavity. It is apparent, however, that precise localization is possible in many cases by means of this apparatus. We may, therefore, expect future development to allow electroencephalography to take its place alongside of pneumocephalography for the localization of intracranial lesions. The advantages of



electrencephalography over pneumencephalography lie in the complete lack of pain and of danger in the former procedure (Bohn<sup>10</sup>).

Since January, 1938, the authors have been working at Harper Hospital taking electrencephalograms on available interesting cases. We do not have enough cases of any one kind to publish at the present time but we have found many records to be valuable clinically in differentiating and localizing many cerebral disorders.

It would be unfair in a discussion of the field of brain waves to disregard mentioning the interesting but dangerous ground of mental aberrations. Although no correlation of the alpha waves with intelligence can be established (Kreezer<sup>29</sup>) it does appear that confused mental states may readily show up on the electrencephalogram. Hoagland<sup>24,25</sup> has seen the coming events of the schizophrenic patient forecast by the electrencephalogram. Davis has presented suggestive evidence relating personal characteristics with the percentage of alpha rhythm in the state of repose (Davis, et al,<sup>13</sup> Davis<sup>15</sup>).

The electrencephalogram is, therefore, an objective record of the electrical energy manifested by cortical function. Surely this record with its abnormal variations may become as important to the neurologist and clinician as the electrocardiogram has been to the cardiologist.

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## NEWER STUDIES AND EXPERIENCES WITH LATEX PROTECTIVE RUBBER SURGICAL DRESSING

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The milky juice as it is obtained from various tropical plants is commonly called latex, commercially preserved by the addition of ammonia. To produce a product adaptable for a surgical dressing the latex is treated with accelerators and anti-oxidants which are colloids, and then allowed to cure in air. The result is a transparent, translucent, water-proof, airtight, adhesive, sterile protective coating. Latex is a carbohydrate. Its chemical structure is not yet definitely known, but we do know that artificial rubber can be manufactured from Iosprene ( $C_5H_8$ ) by polymerization.

### Effects on Healing

Dr. Maurice Brodie, associate pathologist at Providence Hospital, and the author undertook about one year ago to make skin incisions on the backs of rabbits. Fourteen animals were incised for a distance of 2 cms. on each side of the spine at level of the middle third. One incision had latex compound applied directly to the line of incision; on the opposite a standard gauze dressing was applied for control. The incision with the rubber protective coating was excised in ten, twenty-three, and forty-eight hours, and every day thereafter for thirteen days, together with the control incisions, for microscopic studies for the appearance of fibroblasts, fibrocytes, capillary buds and round cell infiltration. Our experimental results were in accord with the findings of Leon S. Smelo<sup>7</sup> as outlined: "Through a method of qualitative evaluation of the effect of local agents on the velocity of wound repair, it has been demonstrated that the substances tested including antiseptics, stimulants, and inert material failed to affect significantly the processes of repair. Factors other than local dressing appear to play a dominant rôle in determining the rate of wound healing."

In our experiments the fibroblasts, fibrocytes, and capillaries made their appearance at about the same time in both the control and the incision with the rubber protective coating.

### Predisposition to Infection

In none of our animals did the control and the questioned incision show any changes in the different cellular infiltrations. We applied the protective rubber surgical dressing on most of our dry, clean surgical cases since September, 1935, since which

time, we have had only one incisional abscess. This was a case that two weeks after onset of drainage an undigested piece of chromic catgut about 2 cm. long was removed from the draining sinus; this was followed by immediate repair. Altogether the material was applied to over two hundred clean surgical cases. Dr. Brodie has examined the material bacteriologically and has found it sterile, even after being tubed one year. It has a phenol coefficient of less than one and is mildly antiseptic.

### Irritating Factors

It is generally known that ready-made rubber goods such as rubber gloves, may give rise to eczema. The only case reported (Niles<sup>4</sup>) prior to 1933 is that of dermatitis due to a rubber bunion protector. Downing<sup>1</sup> and Halloran<sup>2</sup> have reported cases since that time. M. E. Obermayer<sup>5</sup>, in his studies and experiments on eczema due to hypersensitiveness to rubber, states, "As one can see, a great variety of chemicals are employed in the manufacturing of rubber products. Hence, the reports from physicians taking care of the health of men working with rubber contains a vast number of cases of dermatitis due to external irritants. Dr. P. A. Davis of the Goodyear Rubber Co. who is chairman of the section on Preventive and Industrial Medicine and Public Health of the A.M.A., published a series of articles on the toxicity of substances that were known to produce dermatitis have since been eliminated from the rubber industry in this country wherever possible." Schwartz and Louis Tulipan<sup>6</sup> describe eight workers affected with dermatitis following the introduction of accelerators and anti-oxidants for the first time in a rubber plant. A comprehensive classification of the materials



used in the rubber industry and their hazards to health was recently published by the National Safety Council. In many instances it is not the chemical substance itself but impurities which the commercial product contains that give rise to dermatitis. In the majority of cases the dermatitis was due to one of the accelerators.

The protective rubber surgical dressing the author has developed did not cause a single case of dermatitis or irritation except in a few cases where plain catgut was used and came in contact with the surface of the skin and the rubber dressing. This reaction was in the form of a burn; however, we could not produce these results in rabbits. Since we have ceased using catgut for a skin closure, excepting subcuticular we have not seen this, which was the only complication in two and one-half years of clinical trial.

#### Comfort of the Patient

We have had many cases of bilateral herniorrhaphy. On one side we applied the ordinary standard dry or vaseline gauze; on the other side, the rubber surgical dressing. Invariably, within four days the patient requested the standard or vaseline gauze be removed and the protective rubber surgical dressing be applied. The rubber dressing has been used in several thyroidectomies and the usual soreness of the neck and throat was found to be greatly minimized; so much so, that morphia or other narcotics were withdrawn after twenty-four hours in the majority of cases. The indications for the use of the protective rubber surgical dressing are:

1. All clean, completely closed surgical wounds, where closure has been with any material other than catgut.

2. Preoperative protective coating of the entire abdomen where pre-existing pustules or acne, or dermatitis exists which is dangerous to the aseptic progress of the case. This rubber surgical dressing after it has been air-cured, may be painted with a germicide such as tincture of iodine, and the incision made directly through it.

3. In cases of planned fistula, according to Strauss<sup>8</sup> the skin may be protected against the excretions or secretions, by protecting the healthy skin by a layer of rubber dressing just previous to the making of the fistula. Where the fistulae exist, coating of the

affected skin; the dressing will protect the skin for two to three days under conditions of emersion. The same procedure may be adopted in all cases of anticipated drainage when the drained material may be irritating to the skin.

4. The dressing is especially useful in surgery in infants where the urine and stool may contaminate the wound.

5. As suggested by Frederick Weymann Moric,<sup>3</sup> for holding gauze in place, as eye pads, et cetera the technic of applying the dressing is simple. The most important consideration is that the surface to which it is to be applied be dry. Therefore, we have made it a practice of applying a dry gauze dressing to the incision for twenty-four hours, then removing and applying a thin coat of the rubber surgical dressing directly to the line of suture and about 2 cms. of the surrounding area. A sterile cotton applicator is used to spread and even up the edges. Drying may be accelerated by using an ordinary hair dryer to drive out the aqueous material. Ordinarily, this takes from two to seven minutes, depending upon the thickness of the dressing applied. When the latex compound is applied it resembles milk, but in a few minutes it becomes shiny, transparent, translucent, air-tight and waterproof, and an adherent protective coating. At this time, a coat of ordinary talcum powder, or when indicated, sterile powder should be applied.

The advantages of the rubber surgical dressing are:

- (a) It is economical, as after the first application, it is ordinarily not necessary to reapply it.

- (b) The patient complains of less pain.

- (c) The incision and progress of healing may be observed without changing the dressings and interfering with healing. Where a subcuticular silkworm suture is used with one end buried free, and the other end held by a lead ball fixed flush with the skin, the lead ball is freed from the rubber and withdrawn with the suture without removing the dressing.

#### Summary

1. Latex compound is a sterile, shiny, transparent, translucent, air-tight, waterproof, adherent, protective surgical coating.

2. Indicated as a subsequent dressing in dry, clean surgical incisions, especially in

children and infants, as a protection against fecal and urine contamination.

3. As a primary protection of healthy skin in anticipated fistulæ or drainage, and as a primary coating to the entire operative area with the underlying skin and the overlying rubber dressing sterilized with the application of a germicide, and the skin incision made directly through the rubber surgical dressing.

4. Bacteriologically, the material is sterile and pathologically it has no influence on the velocity of healing or irritation to the skin.

5. Advantages of affording ease of observation of progress; the removal of a subcuticular suture without removing the dressing, the splinting of the edges of the

incision, reducing the incidence of pain and the economy of a single permanent dressing.

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## TEN YEARS OF TREATMENT AND PROGRESS IN A CASE OF CHRONIC MYELOID LEUKEMIA

### The Lipid Distribution in Leukocytes and Erythrocytes

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In spite of the attention that has been directed toward the study and treatment of myeloid leukemia since its original description by Bennett and by Virchow, in 1845, there still remains a great deal of progress to be made in the control of this malignant disease. One of the striking things about myeloid leukemia is the extreme variation that occurs in the duration of the illness. The acute form completes its course in only a month or two, while the chronic types have been known to last as long as ten years.<sup>3</sup> The average expectancy is about three and a half years.

It is seldom possible to follow these cases over the entire span of the disease's activity. This report details a case of chronic myeloid leukemia through a period of over nine years, from onset to October, 1937. This complete and accurate résumé was made possible by the intelligent coöperation and intense interest of the patient, Mr. Burnett Green, of Alpena, Michigan. During these years he has maintained a case history, recorded all of his blood counts, completed a curve representing white cell levels throughout the course, and made all of his own leukocyte counts except when hospitalized.

The patient, Mr. Green, is white and at the time of the onset of the disease was thirty years of age

(1929). There was no history of abnormal blood conditions in the family. He had had an appendectomy in 1914, following an acute attack of appendicitis. Tonsils were removed in 1923. There was no history of chronic or focal infection.

The onset of the disease was typically insidious. For a year previous to his initial examination he suffered intermittent excruciating pain across the lower back, brought on by excitement or sudden exertion. At these times he was obliged to sit down to recover from dizziness and a sensation of "everything going black."

Examination by his family physician in January, 1930, revealed no physical abnormalities other than the spleen being palpated two finger breadths below the costal margin. At that time the total leukocyte count was 27,000.

Upon admission to Johns Hopkins Hospital for examination January 23, 1930, it was found that the spleen had increased tremendously in size and at that time extended down into the pelvis and across



the midline into the right side of the abdomen. The total leukocyte count had risen to 750,000. A diagnosis was made of severe myeloid leukemia which appeared from the blood picture to be of a sub-acute type. X-ray treatment was advised.

The x-ray treatment was carried out at the University of Chicago Clinics, Billing's Hospital, by the Department of Roentgenology under the supervision of Dr. Russel M. Wilder of the Department of Medicine. During the period from January 26 to February 12 the patient received ten x-ray exposures. The exposures were given over the following areas: Left ribs and humerus, right ilium (anterior), left ilium (anterior), lower spleen (anterior and posterior), upper spleen (anterior and posterior), lateral spleen (upper and lower). The technique used was: 200 kv., 25 ma., 6 min., 150 mam., 50 cm. std., .5 cu, 1 al, 20 cm. or 15 cm. in diam. fields. During this period the leukocyte count fell to 167,000 and the basal metabolic rate from +43 to +9. Improvement continued slowly after his return home.

During a second admission, from April 9, 1931, to April 31, 1931, a second series of x-ray treatments were given, with about the same dosage, over three fields, spleen (anterior), left thorax and humerus (anterior), right thorax and humerus (anterior). The leukocyte count at this time was 55,900.

A third period of hospital treatment extended from May 8, 1931, to May 13, 1931. Blood count showed 73,000 white blood cells with myelocytes 10 per cent, metamyelocytes 25 per cent, polynuclear cells 55 per cent, small lymphocytes 6 per cent, eosinophiles 3 per cent. Using the same factors eight exposures were used over the following areas: Anterior lower right femur, anterior upper right femur, anterior lower left femur, anterior upper left femur, posterior right pelvis, posterior left pelvis, posterior upper tibia, posterior thoracic spine.

This third series of treatments was followed by cycles of medication with Fowler's solution. It was taken for twenty-one days, starting with 5 drops t.i.d. and increasing 1 drop t.i.d. until 9 drops were being used t.i.d. This was followed by a three week rest period.

A fourth series of x-ray treatments was given during the summer of 1932 using three or four individual areas. Fowler's solution was continued.

During the fifth series of x-ray treatments in September, 1933, the dosage was increased because of the lessened effect of the roentgen rays.

Repeated leukocyte counts by the patient varied from 4,000 to 40,000 until the latter part of 1934 when the total rose to 100,000 and repeated Fowler's solution seemed ineffectual in reducing it. The Department of Roentgenology at Harper Hospital, Detroit, instituted deep x-ray therapy on January 12, 1935. At that time the patient was described as tall, quite under-nourished, weight 130 pounds, the skin somewhat bluish as if he were having slight dyspnea. The general condition, however, was quite satisfactory. The spleen was moderately enlarged, being five finger breadths below the costal margin. There was no adenopathy. Hemoglobin 10.5 grams, red blood cells 4,200,000.

On October 26, 1936, the total leukocyte count was 162,000. The differential count—myeloblasts one per cent, myelocytes 13 per cent, nonsegmented polys 65 per cent, segmented polys 19 per cent, and lymphocytes 2 per cent.

The Research Laboratory of the Children's Fund of Michigan made chemical determinations of the lipid distribution in the blood of this patient. While these determinations are available for only one case, the

TABLE I. DEEP X-RAY THERAPY TREATMENTS

Treatment No.	Date	Area	Constant Factors—Cone 1, 200 kv. 1½ mm. cu., 1 mm. al., 20 ma., 50 cm. std.
			Dosage
	1935		
1	Jan. 12	Spleen directly	6 min., 120 mam., 20 r.p.m.
2	Jan. 19	Spleen directly	6 min., 120 mam., 20 r.p.m.
3	Feb. 2	Spleen directly	6 min., 120 mam., 20 r.p.m.
4	Feb. 9	Spleen directly	6 min., 120 mam., 20 r.p.m.
5	Feb. 22	Spleen directly	6 min., 120 mam., 20 r.p.m.
6	Mar. 9	Spleen directly	6 min., 120 mam., 20 r.p.m.
7	Apr. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
8	Apr. 27	Spleen directly	8 min., 160 mam., 20 r.p.m.
9	May 11	Spleen directly	8 min., 160 mam., 20 r.p.m.
10	June 15	Spleen directly	8 min., 160 mam., 20 r.p.m.
11	July 5	Spleen directly	6 min., 120 mam., 20 r.p.m.
12	July 16	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Both tibia (ant.)	10 min., 200 mam., 20 r.p.m.
13	Aug. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Both lower and upper legs (ant.)	8 min., 160 mam., 20 r.p.m.
14	Sept. 4	Spleen directly	6 min., 120 mam., 20 r.p.m.
		Lower thighs (ant.)	8 min., 160 mam., 20 r.p.m.
15	Dec. 16	Spleen directly	6 min., 120 mam., 20 r.p.m.
	1936		
16	Jan. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
17	Jan. 20	Spleen directly	6 min., 120 mam., 20 r.p.m.
18	Mar. 5	Spleen directly	6 min., 120 mam., 20 r.p.m.
19	May 30	Spleen directly	6 min., 120 mam., 20 r.p.m.
20	June 15	Spleen directly	6 min., 120 mam., 20 r.p.m.
21	June 26	Spleen directly	6 min., 120 mam., 20 r.p.m.
22	Oct. 3	Spleen directly	6 min., 120 mam., 20 r.p.m.
23	Oct. 16	Spleen directly	8 min., 160 mam., 20 r.p.m.
24	Oct. 24	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
	Oct. 25	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
	Oct. 26	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
	Oct. 27	Spleen (posteriorly)	10 min., 200 mam., 20 r.p.m.
25	Dec. 12	Spleen directly	10 min., 200 mam., 20 r.p.m.
	1937		
26	Jan. 6	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
27	May 1	Spleen (laterally)	8 min., 160 mam., 20 r.p.m.
28	May 19	Spleen (laterally)	6 min., 120 mam., 20 r.p.m.
29	June 5	Spleen (laterally)	6 min., 120 mam., 20 r.p.m.
30	July 27	Spleen (ant.)	7 min., 140 mam., 20 r.p.m.
31	Aug. 26	Spleen (ant.)	7 min., 140 mam., 20 r.p.m.
32	Sep. 13	Spleen (ant.)	10 min., 200 mam., 20 r.p.m.
		Spleen (laterally)	10 min., 200 mam., 20 r.p.m.
33	Oct. 2	Spleen directly	6 min., 120 mam., 20 r.p.m.



duration of the case, together with the completeness of the records kept by the patient, makes the data valuable.

The lipid composition of the plasma, red blood cells and the white cells was determined by the gasometric technic of Kirk, Page and Van Slyke.<sup>4</sup> In addition, the minerals (sodium, potassium, and chloride) were determined in the serum and the erythrocytes by standard methods.<sup>5</sup>

The serum minerals were found to be normal. The plasma lipids, however, were increased above normal values and indicated a slight lipemia. Separation of the plasma lipids into the various lipid fractions revealed that the phospholipid and free cholesterol components were within the normal range. The neutral fat fraction was high and the cholesterol esters strikingly low. Normally the fatty acid esters of cholesterol constitute the greater portion of the plasma lipids and the neutral fat fraction accounts for only a small part of the total fat. In the present case there appears to be a derangement in fat metabolism resulting in deficient cholesterol ester synthesis.

The red blood cells were normal in their chemical composition, with respect to the lipid components, but the mineral content was abnormal, having elevated levels of sodium and chloride.

The lipid analysis of the white cells revealed a low lipid content as compared to the normal values determined by Boyd.<sup>1</sup> The two are not strictly comparable, however, since he used a different method. Boyd and Stephens<sup>2</sup> have shown that the phospholipid and free cholesterol content, which compose 80 to 90 per cent of the total fat of the white cell, varies roughly in proportion to the percentage of neutrophils present. Comparison of the lipid composition of the white blood cells in the present case with those of Boyd,<sup>1</sup> who has so far published the most complete analysis of the leukocytes in leukemia, shows that the findings in this case resemble those he found in chronic lymphatic leukemia.

Table II shows the complete blood analysis in comparison with the normal.

Too great emphasis cannot be placed upon the valuable assistance rendered by this patient in the compilation of this interesting graphic description. The fact that the patient was of superior intelligence and at the

time of his affliction was financially able to investigate his condition has been of incalculable benefit. The patient meticulously made white counts and kept a detailed case record throughout. From his charts and compilations the accompanying graph was made showing the stages of the white cell count as coördinated to the treatments being given at various intervals. Fowler's solution was taken four times during 1937, but has been omitted from the chart because the time of treatment was not available. This is due, probably, to the mental burden of the patient being increased by the death of his wife. It is interesting to note that the two highest peaks on the graph occur during periods just after the death of Mr. Green's wives.

Mr. Green, at this time (November, 1937), is still alive and continues his routine x-ray treatment varied or accompanied by Fowler's solution. The fact that this patient has maintained himself for over nine years is probably attributable in great part to his own efforts and studies. He is still able to carry on his normal business activity.

The patient starts to take the solution of potassium arsenite (Fowler's solution) when the leukocyte count rises to 20,000, increases it up to 27 drops daily and maintains the dosage at that level for three to four days if abdominal cramps and enteritis do not become too severe. When the leukocyte count falls slowly, arsenic is continued at a high level for several more days; when it falls rapidly he begins to reduce the dosage when the white count drops to 20,000, and stops it at 10,000. If the white blood cell count rises to 50,000 he plans to have a deep x-ray treatment at Harper Hospital, Detroit, the following weekend. Throughout the entire illness, to avoid becoming resistant to the effect of the rays or tolerant of the effects of arsenic, he has tried not to use potassium arsenite or x-ray exposures over too long a period.

During the time of arsenic administration the skin becomes hyperesthetic, and as the dosage is increased diarrhea develops, with blood in the stools. Epistaxis of short duration is troublesome when the leukocyte count reaches 60,000 to 70,000. During wet weather he complains considerably of the bones aching, particularly the back and hips.

Mr. Green believes that the onset of his illness resulted from chronic overwork, as

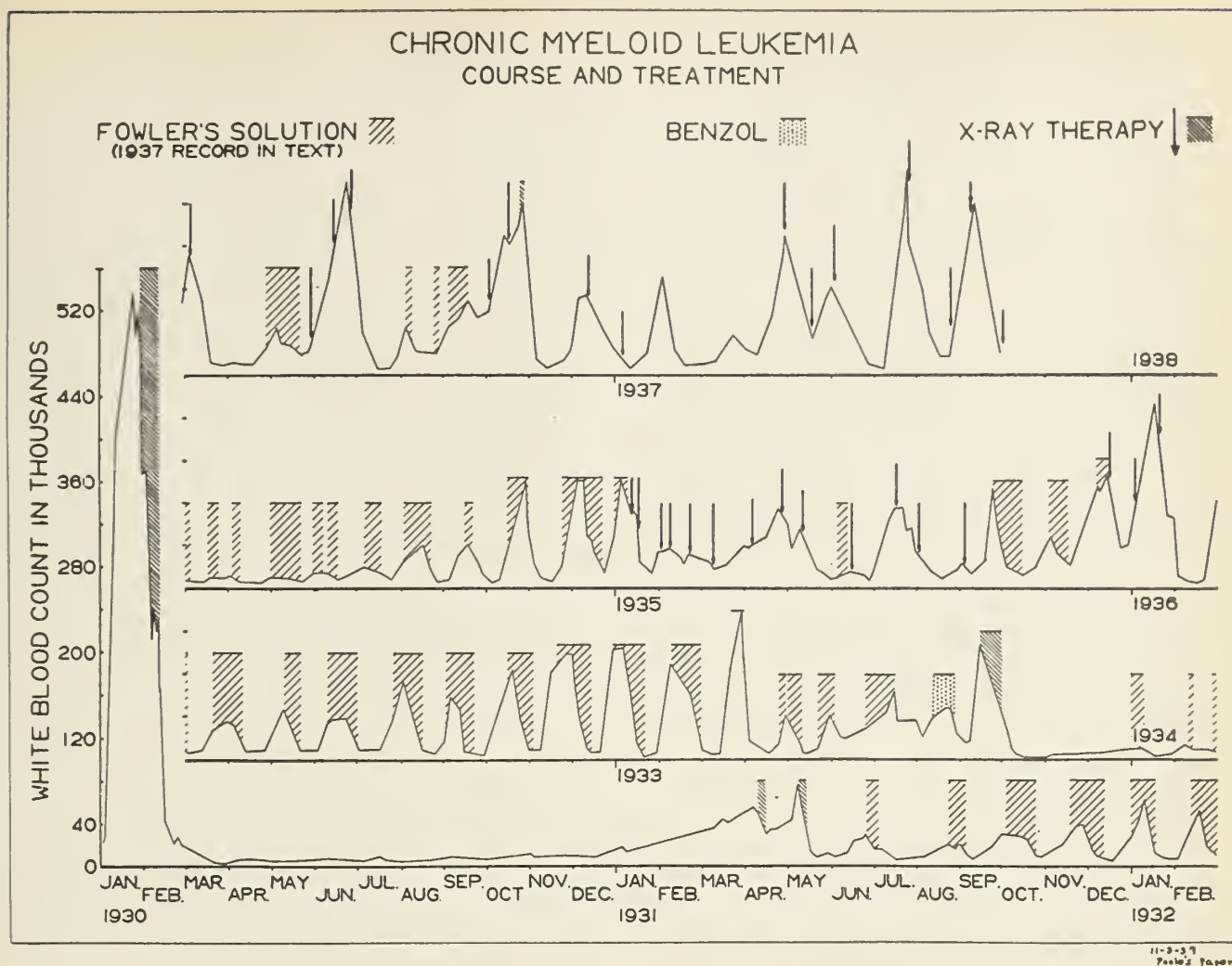


TABLE II. DISTRIBUTION OF LIPIDS IN BLOOD\*

Constituent	P L A S M A			
	Leukemia		Normal (**)	
	Mg. per 100 cc.	Per Cent of Total Lipid	Mg. per 100 cc.	Per Cent of Total Lipid
Total lipid	946		735	
Phospholipid	213	23	181	25
Neutral fat	477	50	225	31
Total cholesterol	194		232	
Free cholesterol	103	11	82	11
Cholesterol esters	153	16	254	35
Constituent	Milli-equivalents per liter			
	Leukemia		Normal (**)	
Sodium	153		140	
Potassium	3.6		4.4	
Chloride	105		103	
Constituent	R E D C E L L S			
	Leukemia		Normal (**)	
	Mg. per 100 gm.	Per Cent of Total Lipid	Mg. per 100 gm.	Per Cent of Total Lipid
Total Lipid	545		424	
Phospholipid	339	62	244	58
Neutral fat	78	14	51	12
Total cholesterol	124		116	
Free cholesterol	119	22	97	23
Cholesterol esters	8	1	32	7
Constituent	Milli-equivalents per liter			
	Leukemia		Normal (**)	
Sodium	27		17	
Potassium	110		104	
Chloride	105		52	
Constituent	W H I T E C E L L S			
	Leukemia		Normal (**)	
	Mg. per 100 gm.	Per Cent of Total Lipid	Mg. per 100 gm.	Per Cent of Total Lipid
Total lipid	543		1455	
Phospholipid	366	67	869	60
Neutral fat	33	6	209	14
Total cholesterol	130		320	
Free cholesterol	110	20	238	16
Cholesterol esters	34	6	139	10

\*July 17, 1935.

\*\*Bibliography reference 6.



well as his mode of living, sleeping irregularly, eating at improper intervals, and traveling a great deal. He also thinks that it bears a close relationship to the emotional shock resulting from the death of his first wife and son in 1928. Calmness and quiet seem to be of value in making it easier to control the white cell level. He relates the rise in the leukocyte count during December, 1935, to the anxiety caused by the serious injury of his wife. During the past summer he has again been subjected to the strain consequent to the death of his second wife.

The white blood cell level seems easier to maintain within reasonable limits during the hot summer weather, when he can get out into the sunshine. Ultra-violet light from artificial sources seems to do harm rather than good. The diet is rich in all the vitamins and high in calories, one-half pint of cream being included in each day's breakfast. Fatigue is still prominent, so that it is necessary for him to sleep twelve hours or more each night. In order to do this he has had to change his occupation and has been able to found a new business during his pe-

riod of illness. In 1930, he was told he had only a year to live. He has maintained himself over nine years, and while continuing to seek a means of cheating the reaper indefinitely his attitude is cheerful, as he feels he has already lived eight years on "borrowed time."

Since this paper was submitted, late in 1937, the death of Mr. Green has concluded one of the longest and most complete case records of chronic myeloid leukemia. Mr. Green died at Harper Hospital, Detroit, February 4, 1938. For the period from October, 1937, to the time of his death, the following data have been procured through the coöperation of Dr. George Leckie and Dr. Hazen Price, of the Harper Hospital staff. The pathological report is available through the courtesy of Dr. Plinn Morse.

The patient was admitted to Harper Hospital January 1, 1938, with pain in upper left quadrant of abdomen. Pus had been found in urine and temperature had ranged from 100-103°. Loss of appetite and weight. Appeared moderately ill, emaciated, several carious teeth, few râles in bases of both lungs, no



friction rubs, prominent cardiac impulse, marked venous pulsation in neck. Blood pressure: systolic 120, diastolic 45—systolic murmur of blowing type in pulmonic area. Right border of cardiac dullness 3 cm. to right of midsternal line. Abdomen somewhat distended. Tender on left side. Firm mass left on left side extending down to below the umbilicus. Skin dry and discolored. Temperature range while in hospital from 100° to 105°.

Films of hands, pelvis, upper thighs and lumbosacral spine: No changes evident on bone structures of hands, lumbosacral spine or pelvis. In upper portion of right femoral shaft just beneath intertrochanteric line there was a very definite area of increased radiability with a somewhat moth-eaten appearance of the bone. This had not given rise to any expansion of the cortex and there was no evidence of frank destruction and periosteal reaction. There were also several places in the shafts of both femora showing evidence of a destructive process.

Upon admission to the hospital the W.B.C. was only 18,000, notwithstanding the immense size of the spleen. The hemoglobin was 43 per cent and R.B.C. 2,740,000. Juv. polys 49, segm. polys 32, lymphocytes 19. Hypochromia, aniso- and poikilocytosis. Daily white counts from January 26 to February 4 (time of death) were: 16,700; 25,400; 21,900; 27,900; 44,400; 78,900; 107,100; 135,000; 117,100; and 125,000. During this period two series of deep therapy x-ray treatments were given.

Blood chemistry January 27, 1938:

Reticulocytes, 0.5%  
Color index, 0.81  
Erythrocytes, 2,680,000 (mean diam. 7.28 $\mu$ )  
Occasional megaloblasts and normoblasts  
Thrombocytes 525,000, hemoglobin 43%  
Coagulation time, 2 minutes  
Leukocytes, 20,650

Promyelocytes, 7%	
Myelocytes—Basophilic	3%
Eosinophilic	3%
Neutrophilic	25%
Metamyelocytes	3%
Neutrophils, stab.	6%
segm.	3%
Eosinophils	4%
Basophils	18%
Lymphocytes	7%
Plasma	1%
Monocytes	17%

Capillary fragility negative; several monocytes present which have some of the characteristics of myeloid tissue: marked basophil aggregation.

Blood chemistry January 30, 1938:

Sugar	0.126	Urea N	16.2
Creatinine	2.1	Phosphorus	4.2 mg.
Phosphatase	9.7	N.P.N.	66.6 mg.

Urine on five occasions showed many granular casts, a few W.B.C.'s and traces of albumin and acetone. January 29—Pleural rub in left lower chest; January 30—blood transfusion, 100 c.c. January 31—pleural rub left chest. February 2—Evidence of bronchopneumonia in left lower chest, temperature high, pulse rapid—more toxic. February 4—died.

Autopsy report, February 5, showed:

Body emaciated, no purpuric spots or petechial hemorrhages in the skin. Abdomen scaphoid. Firm, smooth mass in left upper quadrant extended to the level of the umbilicus. Lower border of the liver

4 cm. below right costal margin. Generalized shotty adenopathy. External examination otherwise negative.

Usual incision showed panniculus orange yellow and 1 cm. thick. Lower border of the spleen at the umbilicus. Spleen weighed 2,120 gm. and was a mottled purple. White spots varying in size from 0.5 to 1 cm. in diameter throughout the spleen. Spleen was firm and the splenic pulp did not scrape away easily. Intestinal tract, bile passages, kidney and adrenals negative. Liver was somewhat mottled, yellowish light brown color, capsule smooth and shiny, weight 2850 gm. Periaortic lymph nodes were shotty and friable. Right kidney 150 gm., left, 200 gm.

Visceral and parietal pleura on the right side adherent over their whole area. Pericardium negative. Heart grossly negative, weight 400 gm. Right lung was removed with difficulty due to adhesions, weighed 400 gm. and was a mottled grayish color. Left lung weighed 550 gm. and was grossly negative. Other structures of the thorax negative except the lymph glands, which show a shotty lymphadenopathy.

The sixth rib on the left side was removed and presented an invasion into it of a whitish, friable material. Examination of the bone marrow from the sternum showed it to be of a cream color, appearing purulent.

Gross Pathologic Diagnosis: Chronic myeloid leukemia, chronic obliterative pleuritis (right), general atherosclerosis, leukanemia.

Microscopic Diagnosis: Lung—terminal bronchopneumonia with diffuse leukemic infiltration of alveolæ. Heart muscle—negative. Liver—diffuse leukemic infiltration of liver parenchyma. Spleen—leukemic transformation of spleen pulp. Kidney—negative.

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## THE EVALUATION OF URINARY SHREDS IN PRENUPTIAL EXAMINATIONS\*

GEZA SCHINAGEL, M.D.  
DETROIT, MICHIGAN

In connection with the present-day trend toward prenuptial examination for venereal diseases, the medical man is very often confronted with the matter of shreds in the urine.

Shreds consist of leukocytes and epithelial cells enmeshed in mucous or fibrous substances. They might appear after any urethral inflammation—not necessarily only after gonorrhea. Their origin is largely due to epithelial cell metamorphosis of the mucous membrane or glands of the urethra.

The color of shreds changes from gray to yellow-white, the lighter color indicating the increased leukocyte content.

A large number of shreds is always suspicious; a single shred, especially after a longer urinary retention (three to five hours) could be neglected. Macroscopically the light shreds, which usually float in the urine, are due to superficial mucous irritation or congestion, as in a chronic infection, or they might be epithelial filaments, which originate during the restorative (healing) process of inflammation. They are finely curved and two or three are found together.

Large comma-like mucoid shreds indicate a chronic inflammation as prostatitis; small comma-like transparent shreds, which microscopically consist of an epithelial lining, might be derived from a Littre's gland or collicle, or masculine utricle, or from the prostatic duct.

The heavy shreds, which sink to the bottom of the glass, are always mucopurulent and indicate a subacute or acute process.

We find also very long, small, thin, opaque, and sometimes transparent shreds which are derived from the prostate and seminal vesicles.

Sometimes we find 1 to 1.5 cm. long, thin, finely-tortuous shreds in which are enmeshed small vesicle-like transparent globes. They originate in the ejaculatory ducts and consist of leukocytes, mucin, and sometimes spermatozoa.

For microscopic examination we must place a shred on a slide and stain it. The technic is very simple. Pass a platinum loop through the flame and with it fish out one or two filaments and place them on a slide. Or let the shreds sink to the bottom of the urine, remove the superfluous urine

and fill it up with distilled water several times, removing thereby the salts in the urine which might disturb one's view. A centrifuge would hasten the process. Fish out the shred, or, if this is difficult, pour the urine in a Petri's dish containing a slide, thereby placing the shred on the slide. Dry off the excess moisture with blotting paper and break up the shred on the slide with a circular movement of the platinum loop over the surface, thereby making as thin a film as possible.

For staining, methylene blue is used. In a slide with shreds, mucin, epithelial cells, leukocytes, and bacteria, which are common in the normal urethra, are generally found. Occasionally there are diplococci, which always indicates Gram staining for the exclusion of any gonococci.

If the smear shows mostly epithelial cells, mucin, and only a few leukocytes, it is not necessary to investigate further, but if the leukocytes are in the majority, one must be on guard, because leukocytes indicate inflammation and inflammation in the urethral mucous membrane is always suspicious of gonorrhea; therefore, a Gram staining several times should be made as well as a culture.

Convinced that there is no gonorrhea present, a search for other sources of an inflammation, because there are patients who never had gonorrheal infection and yet have shreds, should be undertaken. Such sources might be the treatment-resistant, non-venereal urethritis, urethritis after frequent prophylactics, after catheterism, phosphaturia, chronic induration of the urethral mucous membrane, urethral stricture, ulcers, stones, foreign bodies, neoplasm, villi on the bladder sphincter, and on the verumontanum. For clearing up these sources, urethral endoscopy is employed.

\*From the Urological Division, City Physician's office, Detroit.



Other sources are peri-urethritis, Cowperitis, when the gland is palpable between the anal ring and the lower border of the prostate, and prostatitis. In the normal prostatic smear occasional leukocytes are present, but if there are one or two present in every view, there is inflammation. This does not necessarily mean gonococcal, as they might be due to masturbation, interrupted intercourses, bicycle or motorcycle riding, or following pneumonia or influenza.

If the shreds do not disappear after treatment, according to the sources mentioned above, we do provocative treatments which consist of maximal dilatation of the urethra several times in one sitting, and injection of a 2 to 5 per cent solution of silver nitrate

or pilocarpin solution, 0.5 mille per cent, several times daily (according to Japanese investigators), the consequent discharge and shreds being examined for several days for gonococci.

### Summary

1. Shreds in urine should be microscopically examined for nuptial permits.
2. Shreds in urine do not indicate gonorrhea; they point only to an inflammation, the source of which should be satisfactorily explained.
3. The size, shape, and weight of a shred are not satisfactory guides to judge the location or severity of a urethral inflammation.

4400 Livernois.

## VISUAL STANDARDS FOR OPERATING MOTOR VEHICLES

Recognizing the increasing necessity for greater care in the operation of motor vehicles on the highways, the House of Delegates of the American Medical Association at the recent San Francisco meeting adopted the following resolution. The standards set forth were developed by the Section on Ophthalmology, where this program had been under consideration for many years:

*Resolved*, That the following be accepted as the approved American Medical Association standards:

### A. For an Unlimited License:

1. Visual acuity with or without glasses of 20/40 Sn. in one eye and 20/100 Sn. in the other.
2. A field of vision of not less than 45 degrees in all meridians from the point of fixation.
3. The presence of binocular single vision.
4. Ability to distinguish red, green and yellow.
5. Night blindness not to be present.
6. Glasses when required be worn while driving and those employed in public driving and those employed in public transportation be provided with an extra pair.

### B. Visual Standards for Limited License:

1. Visual acuity of not less than 20/65 Sn. in the better eye.
2. Field vision of not less than 60 degrees horizontally and 50 degrees vertically from point of fixation in one eye.
3. Diplopia not to be present.
4. Glasses to be worn when prescribed.
5. Coördination of eye, mind and muscle to be fully adequate to meet the practical visual road tests.
6. A limited license not to be issued to those employed in public transportation.

### C. Renewals, Retesting and Reexaminations:

1. Renewals of license to be issued at least every third year. The applicant shall with each renewal make a declaration that he knows of no visual defect which has developed during the past year.
2. Retesting of acuity to be made at least every six years.
3. If any visual defects have developed, an examination by an ophthalmologist and the report thereof, to be required before re-issuing the license.
4. License to state thereon the specific limitation for driving.

—*Jour. A.M.A.*, Aug. 20, 1938.

# THE JOURNAL

OF THE

## *Michigan State Medical Society*

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NOVEMBER, 1938

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

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## EDITORIAL

### CREDIT TO WHOM CREDIT IS DUE

"AND yet, by any measure we can apply through historical comparison or contemporary statistics, we do now appear to be at the very zenith of a period of amazing improvement in health. In fact, never before has any substantial part of our population, nor has at any time recorded history of man, any population of such size, diversity or racial, climatic and social conditions in any other continent or under one government been so relatively free from communicable disease, so likely to have its children survive the hazardous years of infancy and early childhood, or to so nearly approach the Biblical term of years of life.

"If, as the spokesmen and women of the

technical committee and interdepartmental board in Washington have recently announced, the facilities for public health are grossly insufficient, it may be well to remind them that it is not by their efforts that we have reached the summit of the foothills of health, and that less extravagance of statement would better become a federal government which now offers little new to us, other than to put our children and grandchildren more deeply into debt for their health, so that it, the present federal administration, may claim merit for doing, suddenly and at great cost, what society and medicine have been achieving slowly, steadily and surely within the means of thrifty communities to pay as they go. True there are mountains of unnecessary disease and human suffering to be tunneled, scaled, or worn down by the gradual erosion of scientific progress, but human biology can rarely be hurried, even by billions, and it has a way of making its more enduring advances in human survival by evolution rather than by revolutionary variants in social method."—DR. HAVEN EMERSON (see Andrew P. Biddle lecture, leading article this number of THE JOURNAL M.S.M.S.).

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### DIVIDE ET VICI

THERE is an old saying, possibly Shakespeare said it first, that a rose by any other name would smell as sweet. There has been much adverse discussion in this country of the various political isms, including totalitarianism, a mouthful in itself. No matter what the ism, the effect on the individual is the same, namely, the deprivation of certain liberties which he enjoys under a democracy. We have said this time and again in various forms and it will doubtless be necessary to repeat the idea with variations in the future.

The American people for two or three federal elections past have had the question, Do you want socialism? put to them in the form of a socialist candidate for president. The answer by and large has been most emphatically, No! and yet it would appear that the very thing which the American people in mass turn down, they are willing



to swallow if given to them piecemeal. There is an old Latin saying, "divide and conquer," which carries with it a moral. Any task which appears to be huge in its totality may be accomplished by dividing and attempting a little at a time. Probably the single outstanding attribute of totalitarianism, which by the way includes all the isms so far as political philosophy is concerned, is the centralization of power, till in the last analysis, it is centralized in the so-called strong man.

It is almost unnecessary to mention that in this JOURNAL there is no attempt to discuss party politics, so that when we speak of limitation of federal power, or decentralization of power, we do not have in mind either a democratic or republican government. "The heady wine of power" is bad wherever we find it. We advocate as much liberty for the individual as is consistent with the liberties of all other individuals; also liberties for groups so long as this freedom does not interfere with the rights of other groups.

Now then. In the offing is the Welfare Organization Bill in this state, a measure devised for the purpose of promoting more efficient public welfare in a number of directions. Let us give the proponents of the measure credit for good intentions. Yet this measure in the last analysis tends to hand over the rights and prerogatives of certain groups together with anything that may be demanded in the future, in the way of amendments or supplements, for federal approval. While this measure, as its title indicates, refers to welfare, it necessarily includes such things as medical, dental and nursing care as well as pharmaceutical service and there is no well defined limit as to what may be included under welfare. Let us not be misunderstood. Our objection is not to the commendable features of this measure which tend to economy and therefore greater efficiency in the administration of this important work; it is to the centralization of authority which appears to be the trend of political movement. Let us have as much decentralization and therefore freedom as possible. John Stuart Mill in his famous essay on Representative Government wrote:

"A people may prefer a free government; but if, from indolence, or carelessness or cowardice, or want of public spirit, they are unequal to the exertions necessary for preserving it; if they will not fight for it when it is directly attacked; if they

can be deluded by the artifices used to cheat them out of it; if, by momentary discouragement, or temporary panic, or a fit of enthusiasm for an individual, they can be induced to lay their liberties at the feet even of a great man, or trust him with powers which enable him to subvert their institutions—in all these cases they are more or less unfit for liberty; and though it may be for their good to have had it even for a short time, they are unlikely long to enjoy it."

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## WE WOULD FAVOR RECIPROCITY

THE United States continues to be a very attractive country to outside physicians looking for a location to practice medicine. Ten years ago, thirty-six physicians from Austria, Germany and Italy located in the United States. In 1938 to date, the number is 390. Many of these physicians are well trained and have occupied teaching positions in some of the most noted schools of medicine in Europe. The various states of the United States have been somewhat liberal in admitting medical graduates from other countries. We see no objection to the admission of qualified physicians who have met all the requirements of the state board of the state in which they seek license. What we do not like is the refusal to admit members of the American medical profession to practice in foreign countries. The liberality in the admission of graduates from other countries to the United States should be at least proportionate to the welcome extended graduates of our own medical schools who may seek a license to practice in those countries.

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## CONTACT THE COUNTY MEDICAL SOCIETY

THE *Genesee County Medical Society Bulletin* quotes the following from Hertzler, "The Horse and Buggy Doctor":

"We hear that there are a lot of tears shed nowadays because one-third of this great 'American People' are without adequate medical care. I wonder where these persons live. I know this country from the Father of Waters west and they are not here, \* \* \* This line of conversation seems to emanate from the same Fount of Wisdom that urged us Kansans to plow up our pasture and sow wheat, and that now advises us to put the grass back and plant shade trees and then give the land back to the Indians and buffaloes. Really, it does seem that a good deal of grief could be spared if people would continue their vociferations to things they know something about or at least to regions where their ignorance is not so conspicuous. Why fools are endowed by nature with voices so much louder than sensible folks possess is a mystery. It is a fact emphasized throughout history.

"Certainly, thousands of people do not have adequate medical care, but it is not because it is not accessible to them. \* \* \*

"\* \* \* Who judges whether or not there is adequate medical care? It is wrong assumptions here that are leading to disastrous conclusions."

These paragraphs call to mind excerpts from the *New Orleans Medical Journal*, published in the September number of this JOURNAL, commenting on Dr. Cabot's statement before the National Health Conference in Washington, to the effect that thousands of young physicians are starving and that the bulk of the lower third of the population is not receiving medical care. We feel, like Dr. Hertzler and also the brilliant editor of the *New Orleans Medical Journal*, that medical care is to be had, and if people do not seek it, who is to blame? Many persons, for reasons best known to themselves, never patronize members of the medical profession. They are inclined to consult cultists and irregulars. Others again refrain from consulting physicians through fear. The physician is not only a symbol of hope, he is also a symbol of the opposite, and many keep away for fear of unwelcome news of their condition that they might hear. What more, however, can a physician do than to endeavor constantly to improve his mental equipment and therefore render a higher degree of medical care for those who seek his services. For those who refuse to consult him, he can do nothing. The fact, however, as announced by Dr. Haven Emerson in Detroit, that the past year has seen the United States the healthiest country in the world so far as morbidity and mortality are concerned, should exonerate the medical profession from the charge of hiding its light under a bushel.

Families or persons in need of medical care should call up or seek advice from the headquarters of the county medical society. Were they informed to do so through the public press, or otherwise, the problem of the distribution of medical care would largely be taken care of.

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Everyone has *some* problem. I never met a completely trouble-free man. It is a sort of compensating law of Nature that if a man is free from financial troubles, say, then he has health troubles or home troubles, or a very exacting and demanding job. If you do not believe this, just ferret about among your friends and you will find that every one of them has some secret trouble or grievance about which they say little but brood much.—A writer in *"Modern Salesmanship,"* London.

## DR. C. D. HART, COUNCILLOR OF THE 12TH DISTRICT

Dr. Clarence Dunbar Hart of Newberry has been elected councillor for the twelfth district. Dr. Hart was born at Cambridge, Massachusetts, on June 19, 1895. He is a



C. D. HART, M.D.

Councilor of the 12th District, comprising the counties of Chippewa-Mackinac, Delta-Schoolcraft, Luce and Marquette-Alger.

graduate of Harvard University with the degrees of B.S., M.D., and C.P.H. He is District Health Officer at Newberry, Michigan. He is also secretary of the Luce County Medical Society and a member of the Public Relations Committee and Preventive Medicine Committee of the State Society. Dr. Hart's election augurs well for his District. His scholarship and experience will prove valuable to his constituents as well as to the State Medical Society as a whole.

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## THE WRITING OF CASE HISTORIES

THE proper writing of case histories appears to be a puzzle to a great many medical writers. This is probably due to the hospital training, or lack of it, whereby certain forms are used, partly printed, so that data may be added by means of single words or phrases. How often, in listening to an account of a clinical case, do we find the speaker give a very satisfactory explanation and comment after presenting his case history as a jumble of phrases or implied sentences, *sans* predicate or *sans* subject. An effort has been made to emphasize the



importance of devoting as much care to the diction of the case history as is bestowed on the paper itself which is submitted for publication. We would strongly urge any would-be medical writer to read some of the case histories which appear in our national journals, or journals devoted to medical and surgical specialties, in order to see what is acceptable for publication. We have emphasized the necessity of complete statements of fact. The author should leave nothing to be implied by the reader.

Now, in regard to abbreviations, we have the following timely advice in an editorial which appeared in a recent number of *The Journal of the American Medical Association*:

"When abbreviations are used in medical papers, in the recording of case histories or physical examinations or in operative or pathologic reports, the meaning should be entirely clear to all who may have occasion to read them. This is not, of course, the case. Abbreviations of medical terms are used obviously to save the time of the writer; too often, however, the time thus saved is wasted many times over by the person who is trying to decipher the meaning originally intended. When placed within a context, many of the abbreviations commonly employed in medicine are reasonably clear to those intimately familiar with the particular field; but when removed from such environment they become even more abstruse. Few readers, for example, can probably identify with ease such fairly commonly employed abbreviations as M. T. R., PcB, P. P. D., M. E. D., s. e. d., M. K. R. or K. P. Even when the abbreviations are placed in the proper setting many medical men would have difficulty in translating PcB into "near point of convergence," M. T. R. into "Meinicke flocculation reaction" or M. E. D. into "minimal erythema dose."

"Although for the uninitiated the ophthalmologists possess probably the worst collection of uninterpretable abbreviations, such as K. P. for "keratitis punctata," Hm for "hyperopia manifest," O. U. for "occulus uterque (both eyes)," M. A. for "meter angle" and so on almost ad infinitum, those in other fields are by no means free of criticism. The average physician would usually interpret P. S. P. as the "phenolsulfonphthalein test," M. L. D. as "minimal lethal dose" and possibly P. P. D. as "purified protein derivative" but others who also may need to translate such initials, including manuscript editors, social service workers and statisticians, may have serious difficulties. Sometimes the attempt at interpretation gives rise to persistent errors of more or less serious nature, such as the reasonable interpretation of *E. coli* as "Endamoeba coli" when it should have been "Escherichia coli."

"Hours sometimes have been spent in attempting to decode the meaning of such abbreviations. The use of such short cuts to expression may be an indication of unnecessary haste, careless recording of notes, or slipshod methods of experimentation and study. Reports are written for the reader, not the author, and the reader should not have to be an expert in cryptography to find out what it is all about."

#### Reward

Work and save, young man, and some day you'll have enough to divide with those who don't.

Niagara Falls *Review*.

## DR. W. H. HURON, COUNCILLOR OF THE 13th DISTRICT

Dr. W. H. Huron of Iron Mountain, the newly elected Councillor of the 13th District, comes to his new position with a background in medicine, which should mean



W. H. HURON, M.D.

Councillor of the new 13th District, comprising the counties of Dickinson-Iron, Gogebic, Houghton-Keweenaw-Baraga, Menominee and Ontonagon.

much to the Society. The son of a physician, he was born at Tipton, Indiana, June 23, 1900. He is a graduate of Ohio State University and did postgraduate work with an internship and residency in surgery at Henry Ford Hospital, Detroit. He is a fellow of the American College of Surgeons and is secretary of the Dickinson-Iron County Medical Society. He has practiced his profession at Iron Mountain for the past nine years.

#### Criticism

Reading his newspaper one morning, a man came across an article in which he was severely criticized. He was furious at the insult and asked a friend how to take vengeance. Should he challenge the author of the article to a duel? Demand a public apology? Sue him?

But the friend was a philosopher.


"You will do none of these things," he replied calmly. "Half the people who have read the paper didn't see the article. Half of those who did see it didn't read it. Half of those who read it didn't understand it. Half of those who understood it didn't believe it. Half of those who believed it were of no importance anyway."—*L'Oeuvre*, Paris.

## *President's Page*

### WIN THE BALL GAME

THE Michigan State Medical Society is at bat in the last half of the ninth inning with the score tied. The winning run is on second base. Can you hit a safe single?

A hit means a win. A strikeout means a tie, with possible loss of the game. "Step into it," take a positive and decisive stance with carefully worked out plans to meet the problem of hospital insurance and medical care where need is shown to exist. Ball games are not won the next day. Don't be a mighty Casey and strike out! Hit the ball!



President, Michigan State Medical Society.



# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## DOES THE FEDERAL GOVERNMENT SEEK TO SOCIALIZE MEDICINE?\*

By HON. PAUL W. SHAFER  
U. S. Congressman, Third District, Michigan  
*Battle Creek, Michigan*

NATURALLY I would not attempt to give a direct answer to this question, but, judging from the various and many activities of the Administration in Washington, I believe it is safe to say that definite steps to socialize medicine will soon be taken unless medical and dental societies act quickly to bring about a greater distribution of medical and dental care to the indigent of the nation, and to those of the low income group.

Men and women of America, have been conscious of the health problems of the nation's poor by a clever campaign of propaganda that, during the past two or three years, has reached into practically every home, are today demanding of government that something be done to solve this problem. They are demanding that something be done to ease the burden that comes when ill health strikes their loved ones. And, all must admit, it is a reasonable demand.

While the campaign for socialized medicine has been steadily gaining ground in America, medical and dental organizations have been quietly seeking to bring greater distribution of medical care to the nation's needy. The mistake that has been made, as I see it, is that until recently the public was not informed of the fact that a solution to this problem was being sought.

Only last week the American Medical Association let it be known that it has long recognized the seriousness of this problem and that it has taken definite steps to solve it.

I was glad to read in the newspapers that the A.M.A. House of Delegates, meeting in Chicago, had agreed with the report of the National Health Conference, held in Washington in July, that "the health of the people of this nation is of direct concern of the government and the health of the im-

poverished and those of lower income groups must be protected."

The decision of the House of Delegates to favor hospital service insurance, expansion of the U. S Public Health Service, the establishment of a Federal department of Health, and other recommendations made by the National Health Conference, indicates that the American Medical Association stands ready to cooperate with the Federal Government, which is necessary if a free medical profession is to continue in America.

Bring relief to the indigent, including those receiving old age pensions, who have so far been neglected, and those on WPA, and the clamor for socialized medicine will cease. This will require cooperation on the part of all medical men and the government. I do not propose to say whether this greater distribution of medical care should be subsidized, but, no doubt this must be considered.

From all I have been able to observe there never has been any complaint from those urging socialized medicine as to the quality of medicine in America. The only complaints heard have been based on the poor distribution of medical service in some areas. Solve this problem and you will, for all time, silence those who are agitating socialized medicine.

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## "M.D. VERSUS DOCTOR"

AMONG the many changes in our daily experience is the significance of the title "Doctor." Time was when the use of that term implied certain educational achievements and professional attainments. As a degree, it was conferred by institutions of recognized standards. In recent years, the title "Doctor" has lost much of its traditional significance. It has been conferred by institutions of no recognized standards and upon individuals with not even minimal educational achievements.

A glance at any office building directory will disclose a list of "Doctors" ranging from the rankest cultist to the legitimate

\*Address delivered before the Battle Creek Academy of Medicine and Dentistry, September 27, 1938.

practitioner of medicine. The appellation, to the layman, carries no differentiating significance.

In view of these facts, it behooves the practitioners of medicine to relinquish the term "Doctor" and use the qualifying degree of "M.D." This is still significant and belongs only to an individual who has pursued prescribed courses of study and has proven himself worthy of its traditions.

### THE GOVERNOR'S SPEECH

Governor Frank Murphy, in sending copy of an address which he gave at the Michigan Health Conference at East Lansing on September 10, wrote to each medical practitioner in the state that he "wishes the medical profession of Michigan, with its nearly 5,000 progressive members, to know that it has the support of the government of this state in planning a more nearly adequate program of health for the people."

"That most valuable resource of the state—human life—must be protected," stated Governor Murphy. "An enlightened government can do much to assist the physician in supplying more and better medical care to those now unable to obtain it. I fully realize, however, that any new program must in no way interfere with the excellent work now being done by the profession. We wish, rather, to supplement that work.

"The coöperation of the individual physician, as well as of the organized medical groups, is needed in order that we shall be able to build soundly and wisely for the present and the future."

### MICHIGAN PHYSICIANS PRESCRIBE

"FEDERALIZED MEDICINE" was discussed by Henry A. Luce, M.D., of Detroit, President of the Michigan State Medical Society, before the Chamber of Commerce Forum in Lansing, October 19.

Dr. Luce demanded that government authorities, charged with furnishing necessities to the indigent, must make means available so that the people of Michigan who need medical care shall have it distributed to them in good and sufficient quantity and quality, "when they want it, from whom they want it, and under such circumstances

as our training and experience have taught us is the best."

"The health of the people of this country has too long been a controversial subject," according to Dr. Luce. "During recent years, various non-medical groups have attained prominence by attempting to prescribe the health services of our country. The most recent action was that of a committee designated as 'The Technical Committee.' Just what is meant by technical in this case is rather ambiguous. It is reasonable to assume that it was not entirely non-political.

"The American Medical Association's House of Delegates last month in Chicago wrote a prescription for our country. Michigan physicians, who are all in accord with the national policy, demand that our Michigan public have the best care available. There is not one kind of care for the unfortunate and another for the well-to-do. We recognize no class, creed, color or economic and social dividing lines. We insist upon the proper authorities making means available that we may achieve our objectives. We have written the prescription. We shall write others as the need arises. The 'pharmacists' are the legislative bodies, both Federal and State. The Michigan medical profession will tolerate no substitutions or nostrums."

### POSTGRADUATE MEDICAL EDUCATION

THE FIRST Postgraduate Convocation, held at the time of the 1938 Annual Meeting, demonstrated the profession's appreciation of the Society's efforts in the field of education. On that occasion, over five hundred members of the Michigan State Medical Society became eligible for the first award, a Certificate of Associate Fellowship in Postgraduate Medical Education. Most of the eligible members presented themselves, in person, for the award. From year to year, like numbers will become eligible for the certificate on the basis of a four-year period. The second period award will be that of Fellowship.

The unique plan, as instituted in Michigan, brings the latest achievements in scientific medicine to the very door of the practitioner. Due to the great size of the State of Michigan and the distribution of physicians, it is very inconvenient and impractical for many practitioners to attend organized courses at the educational institutions. For this group, the weekly lecture plan offers an unusual opportunity for advanced medical education.

To its chairman, James D. Bruce, M.D., and the Committee on Postgraduate Medical Education, too much commendation cannot be given. The growing popularity of the program and the presence of so many enthusiastic members at the convocation are evidences of appreciation.



## WOMAN'S AUXILIARY

President—Mrs. P. R. Urmston, 1862 McKinley Avenue, Bay City, Michigan  
Sec.-Treas.—Mrs. R. E. Scrafford, 2210 McKinley Ave., Bay City, Michigan  
Press—Mrs. J. W. Page, 119 N. Wisner Street, Jackson, Michigan

### PRESIDENT'S MESSAGE

It is my turn to serve this year the Woman's Auxiliary of the Michigan State Medical Society as president.



I wish to acknowledge my deep appreciation to the Board and Auxiliary members of the privilege of attending the national meeting held in San Francisco last June. It is my hope, from the knowledge gained and the contacts I made while there, to further our interests in Auxiliary work.

The program I shall attempt to carry out will be a continuation of the policies of the past years.

In Doctor Collisi's report, as chairman of the Advisory Committee of the Woman's Auxiliary, May 12, 1938, he recommends the following activities:

1. Organization of a woman's auxiliary for each county medical society.
2. That each auxiliary member become civic minded; be a good club woman; and be a member of as many community groups as possible.
3. That she inform herself on state medicine in order to give the medical point of view.
4. That she become a member of the Michigan Health League.
5. That the woman's auxiliary assist the state medical society in its program on public health education; promote radio health programs sponsored by the medical society; and stimulate public interest in social hygiene, cancer education, tuberculosis, syphilis and maternal health problems.

In closing he adds the following:

"The advisory committee realizes the great importance of a woman's auxiliary to the state medical society. The constantly changing social, economic and professional structure of our national government has created many controversial medical questions that need to be intelligently explained to the laity. Women's organizations have always been valuable adjuncts to those of men. Today, more than ever before, man realizes the need of the woman's help in his government, his business and his profession.

"The advisory committee wishes to pay a tribute to the doctors' wives of Michigan for their unselfish interest and splendid coöperation in the mutual problems that have arisen during the year."

State Convention registration report:

Woman's Auxiliary—121 registrations. A total membership, 933. Michigan State Medical Society—2,007 registrations. Total membership, 4,077.

These reports speak for themselves, and I urge each county president to impress upon her auxiliary members the importance of attending the state meetings—and registering.

In the past years much time and effort has been spent in preparing a splendid program for the state meetings. This effort has not been made for Board members, standing committees and delegates alone but for *all* auxiliary members. It is *your* meeting—the event of the year.

We have loyal, well informed women in every

county auxiliary, and from these groups we must choose our future leaders.

I speak from experience when I say to you that the more interest you take in state organization work, the more successful will be your local auxiliary.

In closing, in behalf of my Board members, standing committees and myself, we ask:

Guidance from our national organization.

Action from our Advisory board of the M.S.M.S.

MRS. P. R. URMSTON, *President*.

### Past Presidents Receive Pins

At the Wednesday morning session of the Woman's Auxiliary during the recent state meeting, the past presidents of the organization were presented with pins in recognition of their services to the Auxiliary. These pins are of solid gold in green-gold finish. They bear a half caduceus on a filigree background mounted in an olive wreath within the circle of which is engraved "Past President W.A.M.S.M.S." The presentation was made by Mrs. Charles Tomlinson, President, Woman's Auxiliary, American Medical Society. Those who received the pins were: Mrs. Guy L. Kiefer, Detroit, 1927-28; Mrs. L. J. Harris, Jackson, 1929-30; Mrs. J. Earle McIntyre, Lansing, 1931; Mrs. F. A. Mercer, Pontiac, 1932; Mrs. E. L. Whitney, Detroit, 1933; Mrs. F. T. Andrews, Kalamazoo, 1934; Mrs. A. M. Giddings, Battle Creek, 1935; Mrs. A. V. Wenger, Grand Rapids, 1936; Mrs. G. C. Hicks, Jackson, 1937.

A pin of similar design executed in silver was given to the acting President, Mrs. P. R. Urmston, to be worn during her term of office and to be passed on to her successor.



MRS. F. A. MERCER

### Report of Annual Meeting

The Twelfth Annual Session of The Woman's Auxiliary to the Michigan State Medical Society convened at Hotel Statler, Detroit, September 19 to 21.

The Pre-convention Board meeting of the 1937-8 Board was held at the Woman's City Club, September 20. Following a luncheon, the meeting was called to order by the president, Mrs. G. C. Hicks. The following responded to roll call—Officers: Hicks, Urmston, Christian, Page, Wenger, Kiefer; Committee, Chairmen: Jetnichen, Pyle, Fulkerson, Christian, Geib, Keagle, McIntyre and Whitney; County Presidents: Lang, Snapp, Harvie, Walker, Reisig, and Malcomb.

The minutes of the previous meeting were read and approved.

Chairmen of standing committees were given opportunity to discuss the problems of their work. Those who responded were Mrs. Jeanichen, program chairman, and Mrs. Fulkerson, press chairman.

Mrs. Geib, chairman of revision, read the proposed amendments to the Constitution and By-Laws



and moved their adoption by the Board. After discussion, the motion was approved by a majority vote.

Discussion led by the chairman of the Hygeia Committee, Mrs. Keagle, brought the suggestion, approved by the Board, that a letter of protest be sent to the national Hygeia chairman against the method of encouraging late subscriptions by cutting rates. It was felt that this was unfair to earlier subscribers.

The county presidents were invited to talk over any problems in their field but none responded.

The president presented and explained the national budget and gave items of interest from the national convention in San Francisco, telling of our own exhibit and those of other states and outlining some of the projects which have been undertaken by state and national auxiliaries.

The meeting was adjourned by the president at 3:50 P. M.

\* \* \*

The annual meeting was held in the Ivory Room of the Hotel Statler, Wednesday, September 21. The meeting was called to order at 10:30 A. M. by the president, Mrs. G. C. Hicks. The Address of Welcome was given by Mrs. Ledru Geib, representing the hostess auxiliary, Detroit, and Mrs. Guy L. Kiefer responded for the convention.

Led by Mrs. James H. Dempster, the convention paid tribute to the memory of Mrs. A. A. Francis, Saginaw; Mrs. J. Newell Holcomb, Kent County; Mrs. Frederick T. Reid and Dr. Alice Corbett, Oakland County; Mrs. Leonard F. C. Windt and Mrs. Van Valen, Wayne County.

The minutes of the previous meeting were read and approved.

The treasurer's report for the year was read, showing a balance of \$375.03. It was approved. The report of the auditor of the treasurer's report was read.

The reports from the following standing committees were received and placed on file:

Program .....	Mrs. Jeanichen
Press .....	Mrs. Fulkerson
Organization .....	Mrs. Pyle
Legislation .....	Mrs. Christian
Hygeia .....	Mrs. Keagle
Historian .....	Mrs. McIntire

The Committee on Revision, Mrs. Geib, chairman, proposed amendments to the Constitution and By-Laws as recommended by the Advisory Committee. Mrs. Geib read the amendments and moved their acceptance. Mrs. Whitney seconded the motion. It was moved by Mrs. Kiefer, seconded by Mrs. Hoffman, that the matter be laid on the table until the membership had further time for study and consideration. This motion passed and it was so ordered.

Reports of county chairmen were received as follows:

Bay—read by.....	Mrs. Scrafford
Calhoun .....	Mrs. Howard
Eaton .....	Mrs. Anderson
Ingham .....	Mrs. Vanderzalm
Jackson—read by.....	Mrs. Aler
Kalamazoo .....	Mrs. Lang
Kent .....	Mrs. Snapp
Oakland .....	Mrs. Sutton
(written by Mrs. Z. Rooks)	
Ottawa—read by.....	Mrs. Tappen
Saginaw .....	Mrs. Harvie
Wayne .....	Mrs. Walker
Monroe .....	Mrs. Bond
for Mrs. Reisig	
Lapeer .....	Mrs. Merz

Mrs. Robert Jamieson, Committee of Credentials and Registration, reported a registration of 121 of whom 38 were from Wayne County. The report of the Advisory Committee was read by the secretary, accepted and placed on file.

With the vice president, Mrs. Christian, in the chair, the president, Mrs. G. C. Hicks, gave a splendid report for the year. She was accorded an ovation preceding and following her report.

The Committee on Nominations, Mrs. Harvie, Mrs. Geib and Mrs. Peterson, presented the names of Mrs. L. G. Christian of Lansing for president-elect and Mrs. Roger V. Walker, Detroit, for vice president. There being no other nominations for either office, these nominees were elected by acclamation.

Mrs. Emma Fox, a guest at the meeting, was introduced by the president and addressed the meeting briefly.

The secretary read a letter requesting that the Woman's Auxiliary go on record as supporting the proposed Michigan bill, modeled on the Oregon bill, for the control of the sale of contraceptives. On motion of Mrs. Robb, supported by the assembly, the matter was referred to the Legislative Committee of the State Medical Society.

The Committee on Resolutions, Mrs. Wenger, Mrs. Straith, and Mrs. Scrafford, presented resolutions expressing the appreciation of the convention for the cordial hospitality of the Wayne County Auxiliary, in according needs and courtesies to the delegates and guests. These were adopted. Mrs. Hoffman moved that the secretary be instructed to write a letter of cheer to the convention chairman, Mrs. A. O. Brown, who was kept away by illness. The motion was adopted.

The newly elected officers for the year 1938-39 were introduced by the president, following which the new president, Mrs. P. R. Urmston, was seated in the chair.

President Urmston introduced Mrs. Charles Tomlinson of Omaha, Nebraska, president of the Woman's Auxiliary of the American Medical Association, who graciously addressed the past presidents of the Michigan Auxiliary and conducted an impressive ceremony whereby they were each presented with a pin in appreciation of their services to the organization. The acting president also received a pin which she will pass on to her successor at the end of her term of office.

The meeting was adjourned by the president at 12:20 P. M.

\* \* \*

At the banquet in the Hotel Statler, Mrs. Hicks, president, presided; she and the Executive Board were resplendent in gifts of gardenia shoulder corsages.

Two notable speakers held the attention of the 150 guests: First, Dr. Morris Fishbein, chairman of the Advisory Council, Woman's Auxiliary, A.M.A., gave a dynamic speech from which we trust each county president carried home copious notations for her Auxiliary. Dr. Fishbein was accorded a rising vote of thanks for his courage in holding high the banner of the true science of medicine. The second speaker was Mrs. Lawrence Hess, an extension lecturer for the University of Michigan in the field of social hygiene. She worked during the past summer with the Kellogg Foundation as a consultant in that field. Her address had to do with a well rounded program of social hygiene and followed somewhat the line of thought pictured in the posters which comprised the Michigan State exhibit at the San Francisco convention. Mrs. Hess and Mrs. Hicks conceived the idea of the exhibit which was executed in Grand Rapids under the direction of Mrs. Butler.



The posters were on display at the state meeting on Wednesday morning. They are available to any group who wishes to use them, and may be obtained by writing Mrs. Urmston, president, Bay City.

\* \* \*

The closing session of the convention was the luncheon at the Colony Club on Wednesday and included among the honored guests, our national president, Mrs. Chas. Tomlinson; Dr. Henry Cook, president, M.S.M.S.; Dr. H. A. Luce, president-elect, M.S.M.S.; Dr. L. F. Foster, secretary, M.S.M.S.; Dr. H. R. Carstens, president, W.C.M.S.; Mrs. Guy Kiefer, honorary president, Woman's Auxiliary, M.S.M.S. Again our president, Mrs. Hicks, and national president, Mrs. Tomlinson, were recipients of shoulder corsages of orchids.

The chief address was made by Dr. H. S. Collisi, chairman of the Advisory Committee, Women's Auxiliary, on "Marriage After Forty." So many requests were made for copies of his very illuminating address that he promised mimeographed copies would be made.

Adjournment was followed by the post-convention Board meeting, Mrs. P. R. Urmston, newly elected president, presiding. The new committee chairmen were named.

Appreciation is extended Mrs. Page, retiring secretary, for complete data furnished for this report; also abiding good wishes to her as my successor.

(Mrs. C. B.) CORA K. FULKERSON,  
State Press Chairman.

### American Academy of Pediatrics

The American Academy of Pediatrics, Region III, held its 8th Annual Meeting in Detroit on October 27, 28 and 29. The program was very full and complete and provided an intensive postgraduate course on the subject of pediatrics. The editor regrets that the program was received too late in the month to serve as an announcement to the medical profession.

### Free Medical Assistance Ends for Wealthy Indians

Free medical service for all Indians regardless of wealth is a thing of the past. From now on those who can afford it must pay for treatment.

The charge system, put into effect July 1, is the first step toward making the Indian medical service self-supporting, officials say. Officials do not believe wealthy Indians should receive free medical service.

Treatment still will be provided for destitute Indians without cost.—*Detroit Free Press*, Sept. 14, 1938.

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### OBESITY IN ADOLESCENT CURED WITHOUT INJECTIONS

HORACE GRAY, San Francisco (*Journal A.M.A.*, April 30, 1938), observed two boys with obesity, genital hypoplasia, marked tallness and eunuchoid legs for four years (from 12 to 16) and for five years (age 14 to 19), with diet but no endocrine injections. During observation their builds became sufficiently normal to eliminate any question of the need of added hormone. Treatment was begun by the author's usual obesity diet of carbohydrate 80, protein 60, fat 40 Gm., namely, a bread and flour free regimen but including milk and vitamins. The food was not weighed by either of these patients. As soon as they had shown coöperation in facing the restrictions, the diet was increased, mainly to give a protein of about 1.5 Gm. per kilogram of body weight normal for the patient's age and height. Improvement in slenderization in the first patient is most clearly shown by the weight/stature index as converted into terms of percentile rank; whereas "before" the patient was fatter for his height than 98 per cent of boys of his age, "after" the period of treatment he was fatter than only 76 per cent; that is, 24 per cent of boys his age would be as fat as he.

## The Mary E. Pogue School for exceptional children

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**WHEATON, ILLINOIS**

Phone—Wheaton 66 50 Geneva Rd.

# Proceedings of House of Delegates—1938

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# MICHIGAN STATE MEDICAL SOCIETY

## SEVENTY-THIRD ANNUAL MEETING

### Proceedings of House of Delegates

Book-Cadillac Hotel, Detroit, Michigan

September 19, 1938

#### Monday Morning Session

September 19, 1938

The First Session of the Annual Meeting of the House of Delegates of the Michigan State Medical Society was called to order at nine-fifteen at the Book-Cadillac Hotel, Detroit, Michigan, Dr. Philip A. Riley, the Speaker, presiding.

The following is the roll call for the three sessions:

#### RECORD OF ATTENDANCE

COUNTY	DELEGATE	Session		
		1st	2nd	3rd
1. Allegan	E. T. Brunson, M.D.	x	x	x
2. Alpena	F. J. O'Donnell, M.D.	x	x	x
3. Barry				
4. Bay-Arenac-Iosco-Gladwin	R. C. Perkins, M.D.	x	x	x
5. Berrien	Wm. C. Ellet, M.D.	x	x	x
6. Branch	Robt. L. Wade, M.D.	x	x	x
7. Calhoun	Harvey Hansen, M.D.	x	x	x
	A. T. Hafford, M.D.	x	x	x
8. Cass	S. L. Loupee, M.D.	x	x	x
9. Chippewa-Mackinac	E. S. Rhind, M.D.	x	x	
	D. W. Scott			x
10. Clinton	A. C. Henthorn, M.D.	x		
	Dean W. Hart, M.D.	x	x	x
11. Delta	O. S. Hult, M.D.	x	x	
12. Dickinson-Iron	E. M. Libby, M.D.	x	x	x
13. Eaton	Ed. Imthun, M.D.	x	x	x
14. Genesee	Frank E. Reeder, M.D.	x	x	x
	Robert Scott, M.D.	x	x	x
	Donald R. Brasie, M.D.	x	x	x
15. Gogebic				
16. Grand Traverse-Leelanau-Benzie	C. E. Lemen, M.D.	x	x	x
17. Gratiot-Isabella-Clare	Myron C. Becker, M.D.	x	x	x
18. Hillsdale	L. W. Day, M.D.	x	x	x
19. Houghton-Baraga-Keweenaw	G. M. Waldie, M.D.	x	x	x
20. Huron-Sanilac	J. C. Webster, M.D.	x	x	x
21. Ingham	R. L. Finch, M.D.	x	x	x
	C. F. DeVries, M.D.		x	x
	H. W. Wiley, M.D.	x	x	x
22. Ionia-Montcalm	L. E. Kelsey, M.D.	x	x	x
23. Jackson	Philip A. Riley, M.D.	x	x	x
	James J. O'Meara, M.D.	x	x	x
24. Kalamazoo-Van Buren	Charles TenHouten, M.D.			
	R. J. Hubbell, M.D.	x	x	x
	Fred M. Doyle, M.D.	x	x	x
25. Kent	A. V. Wenger, M.D.	x	x	x
	C. F. Snapp, M.D.	x	x	x
	P. W. Kniskern, M.D.	x	x	x
	G. H. Southwick, M.D.	x	x	x
	W. R. Torgerson, M.D.	x	x	x
26. Lapeer	Herbert M. Best, M.D.	x	x	x
27. Lenawee	A. W. Chase, M.D.	x	x	x
28. Livingston	H. Huntington, M.D.	x	x	x
29. Luce	R. E. Spinks, M.D.	x	x	x
30. Macomb	R. F. Salot, M.D.	x	x	x
31. Manistee	E. A. Oakes, M.D.	x	x	x
32. Marquette-Alger	Vivian Vandeventer, M.D.	x	x	x
33. Mason	R. Farrier, M.D.	x	x	
34. Mecosta-Osceola-Lake	G. H. Yeo, M.D.	x	x	x
35. Menominee	H. T. Sethney, M.D.	x	x	x
36. Midland	Edwin Place, M.D.	x	x	x
37. Monroe	D. C. Denman, M.D.	x	x	x
38. Muskegon	E. L. Foss, M.D.	x	x	x
	E. N. D'Alcorn, M.D.	x	x	x
39. Newaygo	O. D. Stryker, M.D.	x	x	
40. Northern Michigan	C. B. Saltonstall, M.D.	x	x	x
41. Oakland	Otto O. Beck, M.D.	x	x	x
	Palmer E. Sutton, M.D.	x	x	x
	Zea Aschenbrenner, M.D.			
42. Oceana	N. W. Heysett, M.D.			
43. O.M.C.O.R.O.	C. R. Keyport, M.D.	x	x	

COUNTY	DELEGATE	Session		
		1st	2nd	3rd
44. Ontonagon	W. F. Strong, M.D.	x	x	x
45. Ottawa	A. E. Stickley, M.D.	x	x	x
46. Saginaw	Clarence E. Toshach, M.D.	x	x	x
	L. C. Harvie, M.D.	x	x	x
47. Schoolcraft	James H. Fyvie, M.D.	x	x	x
48. Shiawassee	A. L. Arnold, M.D.	x	x	
49. St. Clair	A. L. Callery, M.D.	x	x	x
50. St. Joseph	R. A. Springer, M.D.	x	x	x
51. Tuscola	T. E. Hoffman, M.D.	x	x	x
52. Washtenaw	John A. Wessinger, M.D.	x	x	
	Dean W. Myers, M.D.			
	L. J. Johnson, M.D.	x	x	x
53. Wayne	T. K. Gruber, M.D.	x	x	x
	J. M. Robb, M.D.	x	x	x
	C. E. Umphrey, M.D.	x	x	x
	Ralph H. Pino, M.D.	x	x	x
	E. D. Spalding, M.D.	x	x	x
	R. M. McKean, M.D.	x	x	x
	H. W. Plaggemeyer, M.D.	x		
	R. C. Andries, M.D.	x		x
	R. L. Novy, M.D.	x	x	x
	Wm. R. Clinton, M.D.	x	x	x
	A. E. Catherwood, M.D.	x	x	x
	W. D. Barrett, M.D.	x	x	x
	Douglas Donald, M.D.	x	x	x
	Grover C. Penberthy, M.D.	x	x	x
	Louis J. Hirschman, M.D.	x	x	x
	R. C. Jamieson, M.D.	x	x	
	Fred H. Cole, M.D.	x	x	x
	C. E. Simpson, M.D.	x	x	x
	C. S. Kennedy, M.D.	x	x	x
	H. F. Dibble, M.D.	x	x	x
	Andrew P. Biddle, M.D.	x	x	x
	C. E. Dutchess, M.D.	x	x	x
	Alexander W. Blain, M.D.	x	x	x
	Warren B. Cooksey, M.D.	x	x	x
	David I. Sugar, M.D.	x	x	
	Wm. J. Stapleton, Jr., M.D.	x	x	x
	P. L. Ledwidge, M.D.	x	x	x
	C. E. Lemmon, M.D.	x	x	x
	J. A. Hookey, M.D.	x	x	x
	C. K. Hasley, M.D.	x	x	x
	C. F. Brunk, M.D.	x	x	x
	S. W. Insley, M.D.	x	x	x
	L. J. Bailey, M.D.	x		x
	R. L. Laird	x	x	x
	M. H. Hoffmann, M.D.	x	x	x
54. Wexford	W. Joe Smith, M.D.	x	x	x

The reference committees were appointed.

Dr. Martin H. Hoffmann, Vice Speaker, took the chair.

THE VICE SPEAKER: Next is the address of Speaker Riley.

#### I. SPEAKER'S ADDRESS

The Speaker read his prepared address:

DR. PHILIP A. RILEY: Mr. Vice Speaker, officers of the Michigan State Medical Society and members of the House of Delegates:

Once again time has rolled around the day of our annual meeting. It is a day of reckoning, if you like—accounting for our deeds of the past year. It is also a day of planning—for more than ever our future should be well outlined.

The House of Delegates, when in session, is the supreme body of our organization. You have drafted the constitution by which we are guided and it is your duty to amend it as the need may arise. You have compiled the by-laws under which we operate and you elect the officers to carry on for you while you are not in session. The officers of the society as well as the committees they have

appointed are accountable to you for their accomplishments during the past year.

During the past year, the work of the society has been very ably conducted by the Executive Committee of the Council. As your representative on that committee, I have had ample opportunity to observe the untiring efforts of these gentlemen, and I want to say right now that this society owes a big debt of gratitude to Dr. Henry Cook, our president; to Dr. Paul Urmston, Chairman of the Council; and to our hard working secretaries, Dr. Foster and Mr. Burns. Time away from the practice of medicine seems to mean nothing to these gentlemen. With them the society comes first. There is only one conclusion one may draw—they must be wealthy.

For the past few years, the business end of our society has grown by leaps and bounds. I think I am conservative when I say that it has increased 400 per cent in the last 5 years.

We have twenty active standing committees which will render a report today. Many of these reports will contain recommendations for our future policies. The acceptance and adoption of these recommendations constitutes our future policy. With this in mind it behooves each member of a reference committee to put forth his best efforts in formulating these recommendations.

When we say that the business end of our society has increased, we include the work of the committees. It is more than an honor today to be placed on a committee. It is a duty which carries with it an obligation—an obligation to improve the quality of medical service available to the people of Michigan.

The work carried on by the Committee on Post-graduate Education is unsurpassed. Through its efforts new discoveries and improved methods of diagnosis and treatment are carried to all sections of the State. The people of Michigan are the real beneficiaries of this work.

The obligations imposed upon our Legislative Committee are necessary because of the nature of our government. It is ever changing. New laws by the score are enacted every session of the legislature. It is the duty of our legislative committee to oppose laws which may be detrimental to the health of the people of Michigan and by the same token to help in the passage of beneficial measures.

There are people who claim this activity is motivated only by selfish interests. Such is not the case. For centuries past the protection of the people has been our God-given command. For it is written, "Give place to the physician, for the Lord created him and let him not depart from thee, for his works are necessary." (Eccles., Chapter 38.)

I mention these two committees merely as examples. An equal amount of importance can be attached to each of the other eighteen. They are all vital cogs in our organization.

Aside from all this we have another problem which has assumed avalanche proportions and that is so-called "Socialized Medicine." It has been creeping gradually into this country in one form or another for several years back. But in the past year it has swept down upon us like a snowball rolling down the mountain side; we are in the valley below.

This problem had its inception in various forms, which at the time were quite benign. One might mention, for a starter, group examinations of college students or group examinations of factory workers by group physicians paid for this purpose.

Following on the heels of this we have preventive medicine as practised by local Boards of Health. Then came the free clinic or dispensary age, factory first aid rooms and then industrial surgery.

All of these systems seemed bent on destruction of the relationship between family physician and patient

and free choice of physician became an almost forgotten memory.

The prime purpose of these plans was not intended to destroy our two cherished ideals. As a matter of fact, it was far from it. In the beginning and for a long time patients were referred back to their family physician for treatment. However, as time went on, the ties that bind were severed and our ideals became sacrificial victims to that great American god, "Economic Efficiency."

Then as time rolled on—came the thirties. The byword of the day became "unemployment." Soup kitchens came into existence over night. Factories closed, banks failed and cash money seemed doomed to become a memory.

Out of this chaos arose the Emergency Relief Association, a government project which realized medical care was a commodity which should be paid for. And for the first time the doctor was paid by the federal government for caring for the sick and the patient was allowed free choice of physician.

There were many flaws in this set-up and I do not intend going into that angle of it. The point I wish to stress is briefly this: Organized medicine was woefully negligent and lacking in its obligations and duties at the time. Had our Medical Societies been on the job and had taken a guiding hand, a coöperative spirit with intelligent leadership, the Emergency Relief set-up would have been a far different story. In spite of our lethargic lassitude free choice of physician was maintained.

Today, we are face to face with another crisis. Let's not get scared out of our wits. It isn't the end of the world. Let us keep a cool head about it all. We know the government is trying to institute socialized medicine. Only nine days ago, Governor Murphy held a conference for this purpose. The interest manifested by the doctors was intense. The facts presented, most of us were aware of. It was not news to hear that between fifty and sixty per cent of the people are medically indigent. We have known that for some time. The Governor did not speak of any plan by which these people could be cared for. He had only praise for the doctors who have been carrying this burden always. He voiced the sentiment that the medical profession should be paid for this work, and that the average income of the doctor is far below what he is worth. I sincerely hope that this is a reflection of the sentiment prevalent in our national capitol. He asked us to develop a plan whereby people of low incomes can get good medical care and the doctor get paid for it.

Plain spoken English such as that is, places a big burden on our doorstep. I think we should by all means show intelligent coöperation. Of all the people in this country, the medical profession should know how to run its own business and I think we do. Let us develop a suitable plan for it.

There are a number of doctors who think we should leave things as they are. They are looking forward to a betterment in national economic conditions. If this should come to pass, our problem would be solved. But we have spent eight long years looking toward that goal and it still isn't in sight.

Others advocate a system of sickness insurance. This can be set up as cash benefits to the patient such as is unemployment insurance, or the cash can be made payable directly to the doctor. The latter phase I personally do not approve of. Proponents of this cause claim it will function like the workmen's compensation law. The former method, it is claimed, would function similar to our present health and accident policies. There are many other plans and ideas of plans. You probably heard many of them yesterday.



With all the ideas that are prevalent, it seems as though we should be able to evolve a suitable plan which incorporates our own ideas for medical practice. You, the House of Delegates, are the leaders of the medical profession. You have been selected to sit in this body because of your knowledge of medical practice and of medical economics. Whatever is decided upon at this meeting will be for the good of all of us. Whether or not it agrees with your ideas or mine, we must all abide by it. When we leave this meeting and go back to our homes we must all preach the same doctrine. Any plan which suits the majority of this House of Delegates must of necessity suit the entire medical profession. (Applause)

The Speaker's address will be referred to the Reference Committee on Officers' Reports.

Dr. Riley resumed the chair.

THE SPEAKER: We shall now have the address of President Cook.

## II. PRESIDENT'S ADDRESS

Dr. Henry Cook read the Address of the President.

DR. HENRY COOK: Your President appreciates the honor which has been conferred upon him during the past year in having the opportunity to serve you as your leader in a program of improving the quality of medical care and making it more available to those who need it. It has been my pleasure to visit many of your county societies and to have been honored by you. It has been my happy experience to have enlarged my acquaintance among the profession through the help which you have given me and the work which you have carried on. I can recall no instance in which the profession has not extended to me the kindest treatment. I have had the friendliest coöperation from your officers and your committeemen. I can not conceive of any organization working together in a more friendly spirit or with greater zeal in performing their duties and meeting the responsibilities placed upon them.

One year ago at Grand Rapids, the House of Delegates approved of a program. This program was a broad program of the improvement of medical care, both in the care of the sick and prevention of disease. It also took into consideration the matter of improvement of distribution of medical care. The committees and officers have worked with the State Health Department, through its Commissioner of Health, Dr. Gudakunst, who I can assure you is a real friend of the medical profession, in order that the programs of both the profession and the department of health may be co-ordinated. I am certain this relationship will continue.

It will be impossible to enumerate the work of all the committees. If I fail to mention the work of any one committee I hope they will not in any way consider that I do not appreciate the importance of their work or the efforts which they have put forth.

The delegates to the American Medical Association, without exception, have consulted with the Executive Committee of the Council endeavoring to represent to the American Medical Association the mind of the profession.

The Committee on Distribution of Medical Care sent out a questionnaire and I believe obtained information which will be of value to your Council and officers as well as the committees, to guide them in future policies.

The Cancer Committee has had numerous meetings and I feel has carried on a program of supreme importance to the public and of great help to the medical profession. I would urge more considera-

tion by the profession of this extremely important problem.

The Preventive Medicine Committee, through its sub-committees, and through its own efforts, has had a number of meetings and has outlined plans, many of which have been put into effect, to further a program of preventive medicine jointly with the Health Department of the state in the interest of our people. Let me call your attention in the Hand Book to the work in developing an immunization schedule, which has been distributed to every member of the profession. Through its sub-committee on tuberculosis, it developed a program for the state ready to go ahead as soon as funds are available. They hope to, and I believe will be very helpful in improving the program of case finding and care of, as well as the elimination of tuberculosis. The sub-committee on syphilis control has done a fine piece of work.

The work done by the Committee on Post Graduate Medical Education is outstanding in this country and is an example to other states. Approximately one-third of our profession takes advantage of it annually.

You are all familiar with the work of the Public Relations Committee.

There is now in existence, in practically every county medical society in the state, a Committee on Maternal Health.

The Committee on Governmental Agencies has had numerous meetings with various individuals, the work of whom is of extreme importance to the profession. I believe that many friendships and acquaintances have been made by this committee. These contacts are of supreme importance to the profession. I believe that the work of this committee has made the medical profession more understood, and confidence in our state organization and its activities has been increased. The work of this committee should be carried on diligently in the future.

It is impossible to mention the work of all the committees. This work has cost money to the state society. However, I believe that it has been well spent and it would be false economy to restrict their activities. Various county medical societies have coöperated in this work, in fact as well as to have carried out programs in their own county in their own behalf, they have been of inestimable help to the state society. This work should be encouraged and enlarged. The success of the medical profession in their efforts to improve medical care and its distribution is largely dependent upon the activities of the county societies. Every effort should be made to interest the individual doctor of each county medical society in the efforts of the state and county societies. Our strength, as a profession, is dependent upon having a thoroughly informed profession. The officers of your state society, the committee members and each member of the House of Delegates must realize that he is a leader in the profession and especially in his own community, and he should exert every effort to meet his responsibility. Therefore, let me urge that you, the members of this House of Delegates, seriously study the problems which are discussed in this session and when it is over return to your county society, get together the officers and endeavor to explain to them the program of your state society as approved of by this House, urging them to coöperate the work of the county society with the state organization. After all, that is your duty.

Again, let me repeat, I appreciate the help and cooperation that I have had this year, and I take great satisfaction in the confidences that I have that you will give to Dr. Henry A. Luce, your incoming President, the help that he so much desires. I know



of no one in whom I have more confidence and respect.

Thank you. (Applause)

THE SPEAKER: Thank you, Dr. Cook. The President's Address will be referred to the Reference Committee on Officers' Reports.

We shall now have the address of the President-elect, Dr. Henry A. Luce.

### III. PRESIDENT-ELECT'S ADDRESS

Dr. Luce read the Address of the President-Elect.

DR. HENRY A. LUCE: Mr. Speaker, Members of House of Delegates, Officers and Guests:

You are embarking on a meeting that bids promise of being a milestone in medical matters in the State of Michigan. Your President-elect believes in your ability to successfully meet and solve the problems that are presented to you. It is hoped that your decisions will be arrived at in a truly democratic manner in which each and everyone is allowed full privilege to say what he wants to say. Once having arrived at conclusions, your loyalty to the group will guarantee your support.

Your next year's President expects to make mistakes, but he will depend upon you to correct him and them. They will not be mistakes of the heart, but rather mistakes of judgment.

Your advice and counsel at this time is requested most earnestly at every opportunity and on every occasion. With your help and support, with your loyalty to organized medicine and with your basic elements of good citizenship which always characterizes a doctor of medicine, I pledge you my earnest and best efforts to interpret your wishes and to work for the highest ideals of our profession. (Applause)

THE SPEAKER: Thank you, Dr. Luce. Dr. Luce's address will be referred to the Reference Committee on Officers' Reports.

We shall now hear the Report of the Council. Dr. Urmston, Chairman of the Council.

### IV. REPORT OF DELEGATES TO A.M.A.

(See page 1022)

### V. ANNUAL REPORT OF THE COUNCIL

DR. P. R. URMSTON: Mr. Speaker and Members of the House of Delegates: As in the past, the report of the year's work is in your Handbook, but events happen so fast between the time of publication that the reports become obsolete.

I announced yesterday that we had a copy of the official proceedings of the A.M.A. House of Delegates. We were in error. It was simply a newspaper release. You will have the official report before the meeting is over, as we were just in communication with the A.M.A. and our stenographer took the report and it will soon be transcribed and copies furnished you.

Dr. Urmston read his supplementary report to that as published in the Handbook (Page 30) at the conclusion of which he said:

In our "Annual Report of The Council" published in the Delegates' Handbook, we devoted the final paragraph to "progress" of the Michigan State Medical Society. This progress can best be exemplified by the increases in membership during the past three short years. As of September 1, 1935, the membership was 3,468; as of the same date 1938, the membership was 4,017, an increase of 549 members! As of today, our MSMS membership is 4,043, this marking the first time that the total has gone over 4,000. This is remarkable in view of the raise

in dues, and in the face of curtailed medical income due to the present recession. We believe that the individual member should realize that his small investment in MSMS membership is bringing in rich returns and extraordinary protection.

In our regular report (bottom of page 41 of Handbook), we advised that a brief on the legal status of chiropractors had been developed in the MSMS Executive Office. We are happy to report that the Michigan Attorney General, in an opinion dated August 23, 1938, ruled that the conclusions therein stated are correct. This opinion, together with the brief, will be published in the MSMS JOURNAL.

We are also gratified to report the recent opinion of the Michigan Attorney General dated August 3, 1938, to the effect that the practice of medicine by a corporation is illegal in this state. This illuminating ruling will also be published in the MSMS JOURNAL.

The Council realizes it is time to do something, so far as illegal practice by chiropractors and osteopaths is concerned, but a case carried up to the Supreme Court might leave us in the same status we are in at present. The only way in which the laws might be definitely clarified is through action by the Legislature. When you return, will you give that expression to your county societies and wait until the future, when we know that something definite can be done?

In order to accomplish this, we are not going to ask any raise in dues. In the Upper Peninsula they have stated they are willing to have an assessment. They want something done, and more can be accomplished by an assessment for such a fund than by the raising of dues.

We are striving in our efforts to give you protection and education. I thank you. (Applause)

THE SPEAKER: Dr. Urmston's address will be referred to the Reference Committee on Reports of the Council.

### VI. REPORTS OF STANDING COMMITTEES

#### 1. LEGISLATIVE COMMITTEE

Next we will have the reports of the various standing committees. First is the Legislative Committee, Dr. Christian, Chairman.

DR. L. G. CHRISTIAN: Mr. Speaker, the Report of the Legislative Committee is in the Handbook, and there is nothing further to report. I would like to have the report accepted as in the Handbook.

THE SPEAKER: Thank you, Dr. Christian. The Legislative Committee report will be referred to the Reference Committee on Reports of Standing Committees.

#### 2. JOINT COMMITTEE ON HEALTH EDUCATION

Dr. Corbus will give the report of the Representatives to the Joint Committee on Health Education.

DR. B. R. CORBUS: The Chairman of the Joint Committee has no report other than that given in the Handbook.

THE SPEAKER: Thank you, Dr. Corbus. The report will be referred to the Reference Committee on Reports of Standing Committees.

#### 3. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

We will now have the report of the Committee on Distribution of Medical Care. Dr. Pino.

DR. RALPH H. PINO: We present the material that is in the Handbook.

Dr. Hubbell presented the Plan from Kalamazoo for Reference Committee on Reports of Standing Committees.



### Proposed Plan for Care of Medically Indigent

The principle objection to the present form of medical relief is its lack of efficiency, and the overlapping responsibilities of the various groups concerned. I can only speak of the condition as it exists in our own community, though I suppose with certain differences, similar situations obtain in other communities of the State.

There are three groups to be considered, the patients, the physicians, and the governmental units.

That patients should have free choice of a physician goes without saying. They should not, however, be required to draw their own conclusions regarding the nature of their illness, such as acute or chronic, hospital or non-hospital, nor should any other non-medical individual. I speak of the situation in our community, in which the ERA cares for acute cases at home or in the office, and the city cares for chronic cases and all hospitalization, and that sometimes a distinction is made by the patient or some ERA official. There should not then be a distinction in the type of case or the agency that cares for it.

In considering the physicians, one meets with some of the greatest difficulties. Certain physicians do not wish to care for indigents. That is their prerogative. There are others who wish to care for only certain ones, either, from knowledge of the family, or for certain medical or surgical conditions. There are others who would care for indigents, but not when the work interferes with their private patients. There is also the specialists to be considered, and what constitutes a specialty. In our community, with its open staff hospitals, the great majority of the physicians are general practitioners, who care for nearly all of their work, including surgery. So that in any successful plan for the care of the indigents, the whole local profession would have to coöperate, and each member would of necessity have to suppress his own desires and accept the responsibilities.

The third group is the governmental units, who pay the bills. We will assume for general purposes that all governmental units desire efficient, adequate and economical service; at least that is the principle governing their actions. I can only speak for our own community in which these principles are actually true, both as regards the City Commission, and the Board of Supervisors. It is axiomatic that any governmental unit that contributes money for any purpose, is going to insist on having something to say about its expenditure. This applies equally to Federal, State and local units, and any system of caring for the indigent ill, must recognize this.

I wish to submit then the following plan for the care of all individuals included in Section IV of the outline submitted by the State Medical Society, for local groups. It will be noticed that the groups listed contain those now administered by the State Welfare Department, the judges of Probate, the County Boards of Supervisors and City Commissions. I recognize that the plan is nothing new, but rather a combination of existing or proposed plans.

1. An Executive or Advisory Board consisting of 3 members, one appointed by the State Department of Welfare, or its successor, one by the Board of Supervisors, with the consent of the City Commission, in counties with a large city within the county, and one by the Board of Supervisors, with the consent of the Judge of Probate.

(The above assumes county unit plan of relief.) This Board to serve without compensation, to establish rules of procedure, to act in an advisory capacity, to be incorporated, to have final authority in the payment of bills, and any other powers necessary for efficient administration.

2. This Board to appoint a Director of Medical Relief, with the consent of the local medical society. Said director to be a physician, who is likewise an individual with administrative ability. He is to serve at the pleasure of the Board, and at a salary determined by them. The Director is to serve full time and have no other income from any source relating to the practice of medicine. The Director to employ a staff to carry on the work of the Department, such staff to include nurses, investigators and clerks.

The physicians of the community agree—and unless a majority agree, the plan is pointless—to do all the work of medical care. The patient may call the physician of choice, said physician to make the call if available. Frequent refusal to answer calls to be subject to investigation by the Director and recommendations of a disciplinary nature made to the Board. If the physician of choice is not available then any other choice is permitted. In the absence of any specific choice, the physicians to be called in rotation. If the patient needs hospitalization, the procedure of investigation of economic condition, residence, etc., to be cleared through the Director, with commitment by the Director for the hospital bill. The Director is at all times permitted to ask consultation before hospitalization, if in his opinion the condition warrants. The Director is to likewise have the power to limit the stay in the hospital, and for any extended hospital stay, the responsibility of demonstrating the necessity rests with the physician in charge. Cases of reported illness, other than by physicians to be investigated by the nurses.

The fees paid to physicians and hospitals to be determined at the time of establishment of the plan, by the local medical society and the board, and any unforeseen fees determined by the Director and Board, commensurate with the established fee schedule. Necessity for specialists' services to be determined by the Director, and choice of specialists according to the wishes of the patient. Lists of specialists and their speciality to be determined by the Director and the local medical society.

The Director will also determine eligibility for commitment to the University Hospital, should such be desired by the physicians. If it is desired a whole or part time physician may be employed for the care of institutionalized individuals, such as county infirmary, detention home, jail, etc. All others to be cared for by the private physicians.

The funds for the payment of physicians and hospital bills, and the administrative office, to be provided by the Federal, State and local governments as now. The Director, with the Board, to prepare each year, an estimate of the proposed expenditures for the following year. Any curtailment of income from any or all sources to be prorated among the fees paid. Those funds designated by any governmental agency for any particular purpose, to be so used.

Proper records and other pertinent data to be kept by the Director. Medical nursing, to the extent now provided by the Health Department or other agency to be provided by the Board. Care of contagious diseases, and where they exist, the operation of county and city hospitals, to be under the supervision of the Director.

There is to be no practice of medicine in the administrative office.

Weekly clinics for the treatment of venereal disease may be established at the discretion of the local Medical Society for reasons of economy or social status of the patients.

Accident calls from the hospitals, to be attended by the physicians in rotation according to some pre-arranged plan. Hospitalization of obstetrical cases according to some pre-arranged plan.



I realize the difficulties of this proposal. In the first place the Director is almost a medical dictator so far as the care of the indigents are concerned. There are few physicians of sufficient executive ability to properly act as a Director. The efficient operation of the plan would require the whole-hearted coöperation of all the physicians in a community, and the practice of medicine is too individualistic to secure the coöperation of everyone. And yet the efficient, adequate and economical care of this group of people would require that such conditions be met. I don't imply that this is a perfect plan. I would expect many modifications. The plan incorporates some of my own ideas. But certainly the present day care of the indigent is in a chaotic condition, at least in our community. I realize that as set up the plan is open to political favoritism. The Director and Board would have to be of almost Divine inspiration, and yet I am convinced that in our community at least a similar plan would work. I recognize differences between County Boards of Supervisors and City Commissions that exists in some counties. We are thankful that such does not exist in ours. There is in general the fullest coöperation between elective and appointive officers. The plan does not take into account the frailties of human beings, and yet I still think it would work. The alternative, of course, is what confronts us if some plan is not presented which has some reasonable assurance of successful operation. The issue will be forced upon us.

In such a spirit I submit this for your consideration.

#### 4. PUBLIC RELATIONS COMMITTEE

Chairman L. F. Foster reported that the Report of the Public Relations Committee was complete as in the Handbook.

#### 5. MEDICO-LEGAL COMMITTEE

Dr. Stapleton reported for Chairman McLean that the Report of the Medico-Legal Committee was complete as printed in the Handbook.

#### 6. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION

Dr. Cummings, reporting for Chairman Bruce on the Committee on Postgraduate Medical Education, drew attention to the report in the Handbook, and added the supplemental report:

##### 6 (a). ADVISORY COMMITTEE ON POSTGRADUATE EDUCATION

###### Supplemental Report

A meeting of this Committee was held at twelve o'clock, noon, on September 2, 1938, at the Wayne County Medical Society Building, Detroit, Michigan.

Members in attendance: Drs. A. P. Biddle, B. R. Corbus, H. H. Cummings, C. T. Ekelund, W. B. Fillinger, D. W. Gudakunst, G. A. Kamperman, R. R. Smith, D. I. Sugar, and James D. Bruce, Chairman. Dr. Henry Luce and Dr. Henry Carstens also were present.

Dr. Bruce stated that the purpose of the meeting was to obtain the opinion of the Committee relative to the qualifications for certification of physicians attending the extramural courses for practitioners. He reviewed briefly the plan that had been developed. This plan of continuing medical education attempts to cover the recent advancements in medicine and to present those subjects of interest and value to the practitioner of medicine. Because of the numerous fields to be covered and the subjects to be presented, it had been found necessary to extend the courses over a four-year period.

The chairman presented a list of names for certification as instructed by the House of Delegates at the Annual Meeting of the Michigan State Medical Society, held in Grand Rapids on September 27, 1937. All these candidates for certification have at-

tended 50 per cent or more of the extramural lectures given over the past four years, or have attended the composite courses given each spring in Detroit over a period of four years, or have given satisfactory evidence of having taken comparable postgraduate work either in this state or elsewhere.

The chairman also presented a list of names of those who have attended in excess of 50 per cent of the total number of hours included in the four-year extramural program, but which was completed within three years. The Committee felt it desirable to continue the requirement of four-year attendance on the extramural program, and the following resolution was unanimously passed:

"That the Committee on Postgraduate Medical Education recommends to the Executive Committee of the Council that only physicians who have met the requirements for certifications, as set up by the House of Delegates, be presented with Certificates at the annual meeting of the Michigan State Medical Society."

The list which included the four-year candidates was then approved, pending final action by the Executive Committee of the Council.

It was moved by Dr. Kamperman, seconded by Dr. Smith, and passed by the Committee, "that this Committee go on record as recommending to the House of Delegates at its next session that physicians, in order to receive credit for postgraduate work, be required to attend the courses as recommended by the House of Delegates for four consecutive years, or do comparable work, except in cases of absence from the State, sickness or other reasonable excuse, and that the time limit for completion of the work be not over six years.

The chairman then presented a plan for the recognition of medical activities outside the courses of formal instruction as set up by the House of Delegates. All agreed that such a plan would help stimulate greater interest in educational work and serve to integrate county and other society groups with a central plan of postgraduate education. This tentative plan is based on a unit system of credits, 15 units in any one year being required for qualification for certification for Associate Fellowship.

1. Attendance at County Society meetings (60 to 75 per cent?)	2 units
2. Attendance at State Society meeting.	1 unit
3. Attendance at American Medical Association meeting.	1 unit
4. Attendance at Postgraduate Conference.	1 unit
5. Attendance at a recognized National Meeting.	1 unit
6. Attendance on 75 per cent or more of the Extramural Program	15 units
7. Attendance on yearly composite course.	15 units
8. Attendance on intensive special courses in Michigan Program. (each)	5 units
9. Attendance on formal special courses in recognized specialty to which the attendant limits himself.	15 units
10. Membership in and attendance on approved educational societies and activities.	1-5 units

The presentation of Certificates of Fellowship is recommended not only to those who have earned them by complying with requirements set up by the House of Delegates from time to time, but also to those engaged in teaching and research activities in our medical schools, and those making contributions to medical advance through membership in and attendance on hospital staff conferences.

It is believed that this form of recognition will make the possession of certification more keenly to be desired by our membership who aspire to recognition for acceptable educational activities, regardless of their position and practice, and assist in preserving those democratic ideals so long distinguishing the activities of this Society.

In order that there be at all times an under-



standing of the objectives and activities of all committees of the Society having to do with health education, it is recommended that the chairmen of the following committees be made members, or ex-officio members, of the Advisory Committee on Postgraduate Education: The Preventive Medicine Committee, Cancer Committee, Radio Committee, Maternal Health Committee, Mental Hygiene Committee, and Joint Committee on Health Education.

At the Grand Rapids meeting one year ago, the chairman of this Committee recommended efforts on the part of the Society for the establishment of an Endowment Fund for postgraduate education. The executives of the Society have discussed this matter at considerable length with the chairman of this Committee, and it is gratifying to report that substantial progress is being made toward this objective.

#### 7. CANCER COMMITTEE

The Report of the Cancer Committee was submitted as printed in the Handbook.

#### 8. PREVENTIVE MEDICINE COMMITTEE

The Report of the Preventive Medicine Committee was submitted as printed in the Handbook.

#### 9. ETHICS COMMITTEE

The Report of the Committee on Ethics was submitted as printed in the Handbook, by Dr. L. C. Harvie, who stated that Dr. Porter's diplomacy has smoothed rough spots and made friends.

All reports of Standing Committees were referred to the Reference Committee on Reports of Standing Committees.

THE SPEAKER: I want to thank Dr. Clinton, the Chairman of the Golf Committee, for his work, even though the tournament could not be held.

DR. ROBB: I move that we take up the reports of the Special Committees from the afternoon's program.

The motion was seconded by Dr. Humphrey and carried.

### VII. REPORTS OF SPECIAL COMMITTEES

#### 1. MATERNAL HEALTH COMMITTEE

Dr. H. W. Wiley reported for Dr. Campbell, the Chairman, that the Maternal Health Committee's report was complete as in the Handbook.

#### 2. CONTACT COMMITTEE TO GOVERNMENTAL AGENCIES

DR. HENRY COOK: Mr. Speaker, the full report of the Committee is published in the Handbook.

#### 3. MEMBERSHIP COMMITTEE

DR. M. H. HOFFMANN: Mr. Speaker, the Report of the Membership Committee is found in the Handbook.

#### 4. LIAISON COMMITTEE WITH THE HOSPITAL ASSOCIATION

DR. T. K. GRUBER: Mr. Speaker, I should like to present the report by title, as printed in the Handbook, page 116.

#### 5. RADIO COMMITTEE

DR. C. F. SNAPP: I should like to submit the report that is published in the Handbook.

#### 6. ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

DR. H. W. WILEY: I believe that report is complete as printed in the Handbook.

#### 7. COMMITTEE ON OCCUPATIONAL DISEASES AND INDUSTRIAL HYGIENE

DR. HENRY COOK: I should like to state it is all in the Handbook as far as the Committee is concerned. I have been informed that the same ten-

dency is now taking place in Michigan as in other states, that the state institutions are tending to become the consultants for occupational disease work.

However, I will say that my understanding is that the men in the institutions are charging adequate fees and they are objecting to it, thinking they should get it done for nothing. They are right in the middle of it now, and there is possibly another opportunity there to straighten out the situation. I might say that the men who are in the institutions do not feel they should do that work, and it is in the interest of the profession that they should recognize our rights as well as those of the public.

#### 8. COMMITTEE ON HEALTH LEAGUE

DR. L. R. CHRISTIAN: The Michigan Health League was organized by the physicians, dentists, druggists, and nurses. We had a few meetings, and finally came to the point where the League was about to be incorporated, on June 22nd. Since that time some of us have been just a little irritated that we have had no further meetings.

We believe that this organization can be made a great agent for good. We are hoping that during the next year every member of the various organizations will become an active member of the Health League.

As a similar League has worked out in other states, particularly California, Washington, and Arizona, it has been a great aid to the Legislative Committee of the Medical Society and of the Dental Society of those states, preventing a lot of bad health legislation.

#### 9. LIAISON COMMITTEE WITH STATE BAR OF MICHIGAN

This report appears complete in the Handbook.

#### 10. MENTAL HYGIENE COMMITTEE

DR. M. H. HOFFMANN: Mr. Speaker, the Report of the Mental Hygiene Committee is found complete in the Handbook.

#### 11. ADVISORY COMMITTEE TO PAROLE COMMISSION

#### 12. IODIZED SALT COMMITTEE

These two reports, and all reports of Special Committees, were referred to the Reference Committee on Reports of Special Committees.

DR. J. M. ROBB: I believe next year each chairman of a committee should be asked to present a short abstract on the floor to the delegates. A little summary will clarify our minds as to just what the Committees have accomplished and what their problems have been.

THE SPEAKER: Thank you, Dr. Robb. If I am Speaker next year, I will do that.

If there are any supplementary reports to come in on these special committees this afternoon, they will be heard, because some of these chairmen were not present, even though their reports are printed in the Handbook.

Now, our afternoon session is called for 3:00 p. m. sharp, but it will be possible to start the session at 2:30.

DR. ROBB: I move we recess.

The motion was seconded by Dr. H. W. Plaggenmeyer and carried.

The meeting recessed at ten forty-five o'clock.

### Monday Afternoon Session

September 19, 1938

The meeting was called to order at two fifty-five o'clock, Dr. Riley, the Speaker, presiding.

THE SPEAKER: We will now open the second session of this meeting.



## VIII. REPORTS OF REFERENCE COMMITTEES

### VIII (1). REFERENCE COMMITTEE ON OFFICERS' REPORTS (I, II, III)

The first thing we will take up is the Reports of the Reference Committees, and we will start with Dr. O'Donnell, Chairman of the Reference Committee on Officers' Reports.

Dr. F. J. O'Donnell read the Report of the Reference Committee on Officers' Reports:

Your committee on Officers' Reports, consisting of Doctors Harkness, Day, Catherwood, Cooksey, Snapp and myself, met immediately after the adjournment of this morning's session and we wish to announce that this is about the only reference committee whose material is not printed in the blue handbook for delegates, thereby making our committee meeting very lengthy and difficult.

This may be out of order and perhaps out of the scope of this committee, but we all are in hearty accord with the suggestion of Dr. Robb that a brief summary be given on the floor in the Reports of Committees rather than just referring to the handbook in its entirety.

The reports of the Speaker, President and President-elect were all given this morning and this committee received and scrutinized them in detail and we wish to commend the Speaker, President, and President-elect on the cleanness, conciseness and brevity of their reports.

There being no specific recommendations contained therein, we approve them in their entirety.

Committee on Officers' Reports: LUTHER W. DAY, M.D.; F. J. O'DONNELL, M.D.; A. E. CATHERWOOD, M.D.; CARL SNAPP, M.D.

DR. O'DONNELL: I move this report be accepted.

The motion was seconded by Dr. R. M. McKean of Wayne and carried.

### VIII (2). REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES

THE SPEAKER: We will now hear from Dr. Umphrey, the Chairman of the Reference Committee, on Reports of Special Committees.

### VIII (2a). REFERENCE COMMITTEE ON WOMAN'S AUXILIARY [VII (6)]

Dr. C. E. Umphrey read the Report of his Reference Committee on the Annual Report of the Woman's Auxiliary Committee:

In addition to the report as outlined in the Handbook on page 96, Doctor Urmston appeared before the Committee and reported on several resolutions that were approved by The Council. It was Doctor Urmston's further suggestion that more auxiliary units be promoted through contact by the members of or a committee of members of the State Medical Society. A further suggestion was that a definite program be offered to the Council of the Woman's Auxiliary.

The Committee further offers the following three suggestions: First, the adoption of the slogan "Every member, get a member"; Second, a canvass of the clubs of Michigan with the object of greater representation in lay organizations; Third, the consideration of the possibility of representation in the State and National Congress.

The Committee wishes to recommend the report and recommendations as outlined for adoption. I so move.

DR. UMPHREY: I move the adoption of the report.

The motion was seconded by Dr. W. R. Torgerson and carried.

### VIII (2b). REFERENCE COMMITTEE ON RADIO COMMITTEE [VII (5)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Radio Committee in-

cluding the motion for the adoption of the report.

Your Committee has studied the activities of the Radio Committee as outlined in the Handbook and wishes to add its word of commendation for the splendid programs as outlined. If we were to make a suggestion at this time, it would be to the effect that more time be given in explanation of the medical facilities which aid our citizens in receiving more complete medical care. We believe this type of program would be especially appropriate now because of the numerous changes contemplated. Your Committee recommends the adoption of this report. Mr. Speaker, I so move.

The motion was seconded by Dr. C. E. Simpson and carried.

### VIII (2c). REFERENCE COMMITTEE ON MATERNAL HEALTH [VII (1)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Committee on Maternal Health, including the motion for the adoption of the report.

In this report your Committee wishes to call your attention to paragraph four. We wish to commend the committee on withholding its approval of the proposal herein stated until the majority of physicians in the Northern Peninsula are in favor of the plan.

The Committee wishes to commend Doctor Campbell and his committee for their report as outlined in the Handbook as well as the supplementary report delivered before the House of Delegates this afternoon.

I move the adoption of these reports.

The motion was seconded by Dr. P. W. Kniskern and carried.

### VIII (2d). REFERENCE COMMITTEE ON GOVERNMENTAL CONTACT COMMITTEE [VII (2)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Contact Committee to Governmental Agencies, including the motion for adoption.

Your Committee is aware of the extent of the accomplishments of this committee and heartily agree that these activities should be continued.

I, therefore, move the adoption of this report.

The motion was seconded by Dr. C. F. Brunk and carried.

### VIII (2e). REFERENCE COMMITTEE ON MENTAL HYGIENE [VII (10)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Mental Hygiene Committee including the motion for adoption.

In this report the Committee has confined its endeavor to the scientific approach to subjects which deal with mental health. We would recommend in paragraph three that the word *publications* be changed to manuscripts, and that there be inserted after the word *reviewed* the phrase "at the discretion of the Editor." With these minor corrections, I wish to move the adoption of this report.

DR. UMPHREY: We recommend in paragraph three that the word "publications" be changed to "manuscripts," and that there be inserted after the word "reviewed" the phrase "at the discretion of the Editor."

THE SPEAKER: It has been moved that this report be accepted and adopted. Is there any second to it?

The motion was seconded by Dr. Andrew P. Biddle and carried.

### VIII (2f). REFERENCE COMMITTEE ON OCCUPATIONAL DISEASES [VII (7)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Advisory Committee on Occupational Diseases including the motion for adoption.



Your Committee feels that the work of this committee is important now and will be in the near future, and that it should be continued for another year. I, therefore, move the adoption of this report.

The motion was seconded by Dr. Snapp of Kent and carried.

VIII (2g). REFERENCE COMMITTEE ON PAROLE COMMISSION [VII (11)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Advisory Committee to the Parole Commission including the motion for the adoption of the report.

In this report, your Committee would especially call your attention to the recommendations one of which is that at least one of the five commissioners of the Michigan Department of Corrections might well be a Doctor of Medicine. We believe the recommendations are excellent and that the work of this committee should be continued. I therefore, move the adoption of this report.

The motion was seconded by Dr. C. E. Dutchess and carried.

VIII (2h). REFERENCE COMMITTEE ON MEMBERSHIP [VII (3)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Membership Committee including the motion for the adoption of the report.

Your Committee wishes to compliment the first Membership Committee of our organization on its accomplishments during the past year. We would especially call your attention to the recommendations as outlined on page 114 of the blue book. In regard to these recommendations, we recommend that the succeeding committee view carefully the first recommendation, with the possibility of eliminating any controversial procedures.

With this suggestion, I move the adoption of this report.

The motion was seconded by Dr. Hubbell.

THE SPEAKER: This first recommendation is:

"That, if possible, some activity be initiated by the State Society, to make public the rules of the special societies, and a statement as to the number of members of that Society, possibly through publicity in the JOURNAL."

Do you want to state your recommendation again?

DR. UMPHREY: We recommend that the succeeding committee view carefully the first recommendation, with the possibility of eliminating any controversial procedures.

The motion was carried.

VIII (2i). REFERENCE COMMITTEE ON MICHIGAN HEALTH LEAGUE [VII (8)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Representatives to Michigan Health League including the motion for adoption of the report.

Doctor Christian met with your Committee and discussed at considerable length the possibilities of a Michigan Health League. Your Committee feels that there is a large field of endeavor and that the committee should formulate a program and make every effort to carry it to completion.

With this suggestion, I move the adoption of this report.

The motion was seconded by Dr. William J. Stapleton and carried.

VIII (2j). REFERENCE COMMITTEE ON HOSPITAL LIAISON [VII (4)]

Dr. Umphrey read the Report on the Liaison Committee with the Michigan Hospital Association including the motion for the adoption of the report.

Your Committee wishes to pay tribute to Doctor Gruber and his committee for the tremendous amount of work they have done. It is the desire of the Liaison Committee with the Michigan Hospital Association that your attention be called to an

insertion in paragraph three, page 117, of the Handbook. After the word "disorders" should be inserted the following "after commitment."

The Reference Committee wishes the adoption of this report and recommends further detailed study by the Standing Committee on the Distribution of Medical Care.

Mr. Speaker, I so move.

The motion was seconded by Dr. W. D. Barrett and carried.

VIII (2k). REFERENCE COMMITTEE ON BAR LIAISON [VII (9)]

Dr. Umphrey read the Report of his Committee on the Annual Report of the Liaison Committee to the State Bar of Michigan, including the motion for adoption.

In view of the limited work done by this committee and inasmuch as no member of said committee was present to report, recommend the adoption of the report as published on page 120 of the Handbook.

Mr. Speaker, I so move.

The motion was seconded by several and carried.

VIII (2-l). REFERENCE COMMITTEE ON IODIZED SALT [VII (12)]

Dr. Umphrey read the Report of his Committee on the Annual Report of Iodized Salt Committee.

Inasmuch as the work of this committee appears to be incomplete, we wish the adoption of the report and the continuance of the committee for another year.

Mr. Speaker, I so move.

The motion was seconded by Dr. Alexander W. Blain and carried.

DR. UMPHREY: Mr. Speaker, I wish to move the adoption of the report *in toto*.

The motion was seconded by Dr. A. V. Wenger and carried.

THE SPEAKER: Thank you, Dr. Umphrey.

VIII (3). REFERENCE COMMITTEE ON REPORTS OF THE COUNCIL (V)

I will call on Dr. Brasie for the Report of the Reference Committee on Reports of the Council.

Dr. D. R. Brasie read that portion of the Report of the Reference Committee on Reports of the Council which referred to Membership.

Your Committee submits the following report and recommendations:

Membership

The Society is to be congratulated on the success of the efforts of the Membership Committee; the present total of 4,043 being the greatest in history of the Society and this in a time of depression.

The Committee endorses the recommendation of the Council in regard to constitutional change in Article III, Section 1, to insure that active membership in a County Medical Society shall include active membership in the State Society, that the present section be amended by adding after the words "have been paid" the following sentence: "Membership in a County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized."

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of that part of the report.

DR. T. K. GRUBER (Eloise): Is this a motion that the amendment to the Constitution and By-Laws be adopted?

THE SPEAKER: This is not an amendment to the Constitution and By-Laws. We are just recommending that an amendment be created sometime in the future.

The motion was seconded and carried.

Dr. Brasie read the part of the Report under the heading THE JOURNAL.



### The Journal

The Council recommends an increase in the use of Professional cards in the JOURNAL. This is approved.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. Barrett and carried.

Dr. Brasie read the part of the Report under "Contacts with Governmental Agencies."

### Contacts With Governmental Agencies

The Committee commends the Council on its stand taken in the matter of physicians in State Institutions under the Civil Service Commission being required to care for State employees, but wishes clarification of the point "Receiving payment in kind" and recommends aggressive follow-up of this situation.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. H. W. Wiley and carried.

Dr. Brasie read that part of the Report entitled, "Contacts with Unofficial Groups."

### Contacts With Unofficial Groups

The Committee asks at this time for a statement from a Special Committee of the Council as to why a more "wholesome coöperation" from the State Board of Nurses pertaining to the requirements for Nurses Training School was not received.

THE SPEAKER: Do you want to amplify that?

DR. URMSTON: Mr. Speaker, a committee was appointed to confer with the Nurses' Board of Registration and a meeting was held. At that meeting the group asked for further conference. That meeting was never held. Your committee did everything in its power to act on your wishes, but when the Nurses' Board of Registration and the hospitals said, "It is of no interest to us," that is all we could do. That is why it was never clarified.

DR. HENRY COOK: The problems that were discussed at that meeting, I think, should be somewhat clarified. There are two problems involved in the matter of running an institution of nurses. One is the educational side, and the other is the side of service to those who desire nursing. In the efforts that were brought forward by the medical group, desiring that something be done about furnishing nursing care on certain recommended bases of lowered costs for medical service in various institutions, right away the problem of lowering of the standard of training of nurses was brought forward. I think that is the point upon which each of these negotiations met obstacles. There was a meeting to be held in Lansing. There were certain doctors who were interested at that time, who brought the question up before the House of Delegates—Dr. Oakes, Dr. Arnold, and, I think, Dr. Greene and Dr. King. The second meeting was held, but Dr. Oakes was the only physician who attended.

Dr. Brasie read that part of the Report under the heading "Organization."

### Organization

The Council recommends that your Committee endorses:

(1) The continuation of two secretaries conferences each year, one on the occasion of the annual meeting and the other in mid-winter. Your committee commends the innovation of the Secretaries Conference of the U.P. Societies.

(2) Merger of the Delta and Schoolcraft County Medical Societies.

(3) Partition of the present Thirteenth Councilor District as requested by the County Medical Societies comprising the same.

(4) The re-numbering of the Seventeenth Councilor District in the Upper Peninsula to the Thirteenth Councilor District.

DR. BRASIE: Mr. Speaker, I recommend the acceptance and adoption of this report.

The motion was seconded by Dr. Clinton.

THE SPEAKER: Is there any discussion on this matter? I don't know whether you all understand it or not, but the Thirteenth Councilor District is to be divided and the eastern half included in the Tenth District and the western half in the Ninth. In the Upper Peninsula, two county medical societies, Delta and Schoolcraft, are being consolidated.

The motion was carried.

Dr. Brasie read the recommendation on "Committees."

### Committees

1. The Council recommends that no aggressive legislation be sought by the M.S.M.S. in 1939. This is endorsed.

2. The Committee approves the action of the Council that medical defense be continued in this state but that certain changes be made to make it more efficient as presented in the concrete recommendations of the Medical Legal Survey Committee.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. L. W. Switzer and carried.

Dr. Brasie read the recommendation on "Emergencies."

### Emergencies

Your Committee specifically calls to your attention the following paragraphs in the report of the Council on pages 41 and 42 of the Handbook, as follows:

"Contacts were made with our two U. S. Senators and seventeen Congressmen in Washington on a number of important medical problems before Congress. Friends in Congress were made, especially Congressman Paul W. Shafer of Battle Creek, who championed Medicine in Congress on two memorable occasions."

"In view of the multiplicity and increase of our general problems, the medical profession must sustain its activity and must look for an increase in civic endeavor and quasi-public work, as part of its important and ever-increasing functions."

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. R. L. Finch and carried.

Dr. Brasie read the recommendation on "New Activities."

### New Activities

The Committee endorses the Council's recommendation to its A.M.A. delegates that they use their influence to secure a Public Relations Bureau in the A.M.A.

DR. BRASIE: Mr. Speaker, I move the acceptance and adoption of this report.

The motion was seconded by Dr. Dutchess and carried.

DR. BRASIE: Your Committee heartily commends the untiring efforts of the Council, its Executive Committee, the Officers of the State Society, and the numerous committees as evidenced by the many meetings listed in The Council report, on pages 38 and 39 of the Handbook.

Mr. Speaker, I move the acceptance and adoption of this report as a whole.

The motion was seconded by Dr. E. D. Spalding.

THE SPEAKER: It has been moved and seconded that this report be accepted as a whole. Is there any more discussion now?

The motion was carried.

THE SPEAKER: Thank you, Dr. Brasie.



Will the President-Elect please come forward? (Applause.)

Dr. Luce is to give us a report for the Delegates of the American Medical Association.

#### IV. REPORT OF DELEGATES TO A.M.A.

DR. HENRY A. LUCE: Mr. Speaker, Members of the House of Delegates, and Guests: I hold in my hand a paper which represents all of the important action that was taken at Chicago last Friday and Saturday. We telephoned Dr. West and he agreed to the arrangement that he would get the final copy with all the corrections that had been made in it and telephone that to a stenotype operator this morning. That was done, transcribed, and is now ready for distribution. This constitutes the supplementary report of the members who composed your delegates to that special session. (The report was distributed.)

##### Report of the Summarizing Committee of the House of Delegates of the American Medical Association

Since it is evident that the physicians of this nation as represented by the members of this House of Delegates convened in special session favor definite and decisive action *now*, your committee submits the following for your approval:

##### Recommendation I. Expansion of Public Health Service

1. The establishment of a federal department of health, with a secretary who shall be a doctor of medicine and a member of the President's Cabinet.

2. The general principles outlined by the technical committee for the expansion of public health and maternal and child health services are approved, and the American Medical Association definitely seeks to coöperate in developing efficient and economical ways and means of putting into effect this recommendation.

Any expenditure made for the expansion of public health and maternal and child health services should not include the treatment of disease, except insofar as this cannot be successfully accomplished through the private practitioner.

##### Recommendation II. Expansion of Hospital Facilities

1. We favor the expansion of general hospital facilities where need exists. The hospital situation would indicate that there is at present greater need for the use of existing facilities than for additional hospitals. We heartily favor the approval of the recommendation of the technical committee pertaining to the use of existing hospital facilities. The stability and efficiency of many existing church and voluntary hospitals could be assured by payment to them of the cost of the necessary hospitalization of the medically indigent.

##### Recommendation III. Medical Care for the Medically Needy

1. We advocate recognition of the principle that the complete medical care of the indigent is a responsibility of the community medical and allied professions, and that such care should be organized by local government units and supported by tax funds. Since the indigent now constitute a large group in the population, we recognize that the necessity for state aid for medical care may arise in poorer communities and the federal government may need to provide funds when the state is unable to meet these emergencies. Reports of the Bureau of Census of the U. S. Public Health Service and of life insurance companies show

that great progress has been made in the United States in the reduction of morbidity and mortality among all classes of people. This reflects the good quality of medical care now provided. We wish to see continued and improved the methods and practices which have brought us to this present high plane. We wish to see established well-coördinated programs in the various states in the nation for improvement of food, housing, and the other environmental conditions which have the greatest influence on the health of our citizens. We wish also to see established a definite and far-reaching public health program for the education and information of all the people, in order that they may take advantage of the present medical service available in this country. In the days of the vanishing support of philanthropy, the medical profession as a whole will welcome the appropriation of funds to provide medical care for the medically needy, providing first, that the public welfare administration procedures are simplified and coördinated; and second, that the provision of medical services is arranged by responsible, local public officials, in coöperation with the local medical profession and its allied groups. We feel that in each state a system should be developed to meet the recommendation of the National Health Conference, in conformity with its suggestion that "the rôle of the federal government should be principally that of giving financial and technical aid to states in their development of sound programs through procedures largely of their own choice."

##### Recommendation IV. General Program of Medical Care

We approve the principle of hospital service insurance which is being widely adopted throughout the country. It is capable of great expansion along sound lines and we particularly recommend it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that the plans should confine themselves to provision of hospital facilities and should not include any type of medical care. We recognize that health needs and means to supply needs vary throughout the United States. Studies indicate that the health needs are not identical in different localities, but that they usually depend on local conditions and therefore are primarily local problems.

We therefore encourage county or district medical societies, with the approval of the state medical society of which each is a component part, to develop appropriate means to meet their local requirements. In addition to insurance for hospitalization, we believe it is practicable to develop cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations, to insure their soundness and financial responsibility, and have the approval of the county and state medical societies under which they operate.

We are not willing to foster any system of compulsory health insurance. We are convinced that it is a complicated bureaucratic system which has no place in a democratic state. It will undoubtedly set up a far-reaching tax system with great increase in the cost of government that would lend itself to political control and manipulation, there is no doubt.

We recognize the soundness of the principles of workmen's compensation laws and recommend the expansion of such legislation to provide for meeting the cost of illness sustained as a result of employment in industry. We repeat our conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitaliza-



tion and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

#### Recommendation V. Sickness Insurance Against Loss of Wages During Sickness

In essence, the recommendation deals with compensation of loss of wages during sickness. We unreservedly endorse this principle, as it has distinct influence toward recovery and tends to reduce permanent disability. It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness and of recovery, which function should be performed by qualified medical employees of the dispensing agent.

To facilitate the accomplishment of these objectives, we recommend that a committee of not more than seven physicians representative of the practicing profession, under the Chairmanship of Dr. Irvin Abell, President of the American Medical Association, be appointed by the Speaker to confer and consult with the proper Federal representatives relative to the proposed National Health Program.

The above report was unanimously adopted by the House of Delegates of the A.M.A.

DR. LUCE: That concludes the report. Thank you.

THE SPEAKER: Will you read the report? It isn't long.

Dr. Luce read the Report of the Summarizing Committee of the House of Delegates of the American Medical Association called in Special Session to consider the National Health Program, Chicago, September 16-17, 1938, during the reading of which the following interpolations were made:

1. Page 1: DR. ANDREW P. BIDDLE: I should like to ask if this interferes with the organized Public Health Service.

DR. LUCE: My interpretation of that line is that which has been stated heretofore several times, that the medical profession would like a member of the President's Cabinet to be a doctor of medicine who will be in a position to cooperate with organized medicine.

DR. R. C. PERKINS: I believe this question was asked yesterday also: Would that particular set-up be in any way directly connected with the present United States Public Health Service?

DR. LUCE: I believe it is a separate and distinct new cabinet position. Remember that the A.M.A. House of Delegates couldn't go into the hair-splitting details connected with the problems that were brought up. They made a general statement as a guide of the conduct of organized medicine. There may be some things that you would like to see in here. This committee tried to leave that open enough so that whatever you wanted to put in or interpret in your own individual localities could be done.

\* \* \*

2. Page 1: Unless you want to ask a question, I will volunteer this information. It was brought out that time that they had the syphilis program in the City of Chicago. In order to cooperate definitely with the drive toward the eradication of syphilis it was necessary to hire twenty-five doctors to serve certain portions of the population of Chicago.

\* \* \*

3. Page 2: Again I would like to give you that definition of the medical indigent which we gave yesterday. It is not on the piece of paper which you have, but will probably come in the *Journal of the American Medical Association* and probably in the *Michigan State Medical Society JOURNAL*. This is the important definition that was adopted by the House of Delegates:

*"A person is medically indigent when he is un-*

*able, in the place in which he resides, through his own resources, to provide himself and his dependents with the proper medical, dental, nursing, and hospital care, together with pharmaceutical and therapeutic appliances, without depriving himself or his dependents of the necessary food, clothing, shelter and similar necessities of life, as determined by the local authorities charged with the duty of disbursing relief for the medically indigent."*

Is there any question?

\* \* \*

4. Page 2: By a community project, we mean that the doctors enter into it, the hospitals enter into it, the Boards of Commerce enter into it, the Community Fund enters into it, the Parent-Teacher Association enters into it, and that it can be sold to those who need it.

The cost of insurance, if it is sold by agents, if my recollection serves me correctly, runs anywhere from 35 to 40 per cent more than the cost of a project that is sponsored by the community interests. There is practically no sales proposition because every doctor becomes an agent for it, every social worker becomes an agent for it, and every community service becomes an agent for it, and the expense of sales is largely taken care of. For this particular provision, credit can be given to the State of Michigan.

\* \* \*

In your papers that you have on hand, in the second paragraph, under Recommendation IV, the second sentence, beginning, "In addition to insurance for hospitalization, we believe it is practical to develop," insert the word "cash" at that point—"cash indemnity insurance plans."

\* \* \*

THE SPEAKER: Are there any questions you would like to ask Dr. Luce now?

DR. L. W. DAY: In Recommendation V there is no allusion to disability due to accident. In the realm of insurance there is quite a difference in disability due to sickness and disability due to accident.

DR. LUCE: You can't live near Ann Arbor without acquiring some of the erudition and culture that exist there. Dr. Cummings has called my attention to the fact that there is a word that is misused here, the second to the last word, under Recommendation V. It should be "disbursing" not dispersing.

Dr. Day's question, I think, is very well taken on disability due to accident. If I understand it correctly, in essence the recommendation deals with loss of wages during sickness. That is the particular part. He informs me that the insurance companies recognize a difference between sickness and accident. Is that correct?

DR. DAY: That is correct.

DR. LUCE: I am of the opinion that it was the intention of the committee to include the word "accident" in there, although I doubt if it was put in. Perhaps that can be made an addition at some subsequent time.

THE SPEAKER: Are there any other questions?

DR. R. C. PERKINS: In connection with the words "cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness," in this discussion was there any embodiment therein of the plans whereby the physician would be reimbursed for the services which he rendered in these particular cases?

It may sound commercial, but it is in the interest of economic problems as they affect the physician and not entirely commercial. Cash indemnities are at present paid by insurance companies to the recipients of injuries, for instance, in automobile



accidents, but very often a physician gets no part of that indemnity.

DR. LUCE: As I said at the outset, all of these principles can be elaborated upon. We have frequently stated throughout that arrangements and details of different localities growing out of this must be made with the consent and approval of the local county or state medical society.

May I ask Dr. Leland if he would like to add a word to that?

DR. R. G. LELAND: The committees did consider and discuss methods by which the physicians could receive pay under a plan developed as recommended under Recommendation IV, "cash indemnity insurance."

It must be remembered that at the present time there is a difference in the different states, and there are, in operation in a number of states, methods by which the physician, knowing a patient has some form of insurance, may take steps to safeguard the payment on the cash which is due the patient, either to himself or to the hospital, by some form of assignment clause or other method.

It was thought, however, by the committee, as I recall it, that it would be better at this time for the main committee to confine itself to principles and to permit the state and county medical societies to consider appropriate measures pertaining to the payment in the plans which they develop in their own jurisdiction.

DR. HENRY COOK: Mr. Speaker, I think in the discussion before writing in the word "cash" benefits, the point was brought out that that eliminates the possibility of the employment of a physician to render a service. By putting in "cash" benefits it gives the one who carries the policy more liberty to choose his own physician and have the money available to pay him.

I think that was written in that way because of the experience some of the physicians and surgeons have had where they have these plans now. They found it was better to get away from the insurance company's hiring someone on a salary and offering to furnish medical service on that basis, desiring to retain a physician by a deposit.

DR. T. K. GRUBER: I believe at the San Francisco meeting of the American Medical Association, action was taken upon the matter of health insurance in particular, that there was no objection to health insurance that was paid in cash indemnities as opposed to payment to the individual who rendered the service. I believe that was brought up by this discussion, and it was changed on the floor of the House, as they were reading it, to conform with the action of the House of Delegates at San Francisco.

DR. R. J. HUBBELL (Kalamazoo): May I ask a question? I wonder if we can have a clarification of the third sentence under Recommendation V: "It is, however, in the interest of good medical care that the attending physician be relieved of the duty of certification of illness," etc.

It doesn't seem that recommendation is good to me. I would like to have it enlarged upon.

DR. LUCE: The doctor's question is in reference to the last sentence in the first paragraph of Recommendation V, relative to relieving the attending physician of the certification of illness and of recovery. In brief, it is taking the physician off the spot.

DR. HUBBELL: I understand that, Doctor, but perhaps we are relinquishing some opportunity and prerogative we might have. Many times we are on the spot, but I think it might be better to be on the spot than to be under the control of some-higher employee of the insurance company.

DR. LUCE: That was discussed at great length. I think you can all see that the doctor is right in

bringing up this point, and yet the final conclusion of the committee and of the House of Delegates was that it was a safer proposition to leave it as it was written.

DR. GRUBER: Mr. Speaker, if Dr. Luce will remember, when this came on the floor of the House they had to take a recess, and about fifty men went out and conferred with the Chairman of the Committee, and we were held up about twenty minutes or longer while this was being discussed and rewritten. There was a great deal of discussion on just this subject.

One of the ideas in mind was that some person wanted to know if he had to make out a whole stack of reports on the proposition, and so the discussion went from one thing to another until finally they recessed and sent the committee out to rewrite it, and this is the way this group of men who went out with the Chairman came in and presented it.

THE SPEAKER: As to the Report of the Delegates on the San Francisco meeting of the American Medical Association, that report is in the Handbook. I am going to call on Dr. Gruber to give us a synopsis of that June meeting, so that we can match that up with our supplemental report and handle the report as a whole rather than individually.

DR. T. K. GRUBER: Mr. Speaker and Members of the House of Delegates: The members of the House of Delegates apparently had certain ideas in mind regarding the whole question of the attitude of the public toward the medical profession, and several groups had talked over the matter of all of the adverse publicity that medicine has had through the magazines, through the various publications in the United States, and certain attempts were made in various ways to try to establish that which was adopted here today, a Public Relations Committee for the American Medical Association and the medical profession in this country. Michigan introduced an amendment to the Constitution and By-Laws which would have set up a Public Relations Commission, separate and apart from the present organization. By that I don't mean it was to be a different group but it was to be a new set-up in the form of a Public Relations Committee.

There were other resolutions presented on the same subject. The recommendations as they were presented failed to pass, but Dr. Luce's committee report, which was to the effect that there was some discussion, recommended that the American Medical Association continue with the same amount of vigor and the same amount of pressure the policies that they have pursued for a great many years. They recommended, however, that probably a little oil poured on the waters might help to set up a better relation between the public and the medical profession.

The American Medical Association had invited Miss Josephine Roche to appear before the organization and present her views on her interpretation of what the Technical Committee, which was to have a meeting a month later, had in mind. Miss Roche was not able to be present. It was explained by Dr. Olin West, the Secretary, that Miss Roche is a very busy woman in her own personal affairs, that she has a great many industrial activities, and that certain of these activities were in such position that she couldn't leave them at this particular time, and she begged leave to be excused from coming to the meeting, and sent Dr. W. F. Draper of the Public Health Service to read her paper.

I believe this paper has been published and you have read it. If my memory serves me correctly, the import of the paper was that if medicine doesn't do something, somebody else is going to. That summed up the story very well.

The House of Delegates then authorized repre-



sentatives of the American Medical Association to attend this conference at Washington, which was held on the 18th of July, and most of you have seen the results of that. It has been talked over and part of what Dr. Luce read here is an outgrowth of that particular conference.

Another thing that was brought out was the matter of differentiating between indemnity insurance and insurance—I should say probably insurance-in-kind. I was informed that the House of Delegates of the American Medical Association was not opposed to indemnity insurance in which the money was paid to the individual who was insured and he, in turn, reimbursed the doctor or the hospital or whomever it might be.

The roentgenological group and, I believe, the pathological group and certain other groups, introduced a resolution to the House of Delegates, the purpose of which was to affirm what was already a matter of common knowledge; that is, that the roentgenologists and the pathologists are practitioners of medicine. I have forgotten just how many groups were included in that, but at least the roentgenologists and pathologists are included.

In regular session, the House of Delegates voted to amend the association's "Ten Commandments" concerning socialized medicine to disapprove the inclusion of special medical services, such as pathological examination, x-ray work and anesthesia, in group hospital contracts and providing for removal of hospitals from association's approval list where either the public or profession is exploited.

The idea was in mind that any hospital that transgressed from the principles of the American Medical Association would no longer be approved as a proper place for internes and residents.

I move the adoption of the report as printed in the Handbook.

The motion was seconded by Dr. C. F. Snapp.

THE SPEAKER: Is there any discussion?

The motion was carried.

THE SPEAKER: It is a peculiar thing that this year we have the largest attendance of delegates we have ever had—101 out of a possible 106.

Now, we will take up the continuation of the supplementary report which Dr. Luce has been going over. Are there any more questions you wish to ask?

DR. LUCE: Mr. Speaker, I move the adoption of the supplementary report.

The motion was seconded by Dr. Stapleton of Wayne and carried.

THE SPEAKER: Thank you, Dr. Luce.

## IX. NEW BUSINESS

Is Dr. Reeder in the House? Will you please come forward?

### IX (1). KEY PRESENTED TO FRANK E. REEDER, M.D.

Gentlemen, I want you to behold the delegate from Flint. He has been coming down to the House of Delegates for about twenty-six years, more or less. He was Vice Speaker of the House of Delegates for two or three years, and he was Speaker for two years. He has entertained us during the evening hours on many occasions. Sometimes we laughed at his jokes, but we had heard them before. (Laughter) But now and again he used to come along with some new ones. He has been on a number of committees for the State Medical Society and has worked very hard on them. He was a very good Speaker of this House of Delegates, and now he is back as a plain delegate again.

In recognition of all the faithful service that he has given to this Society, the House of Delegates has had made a key, which, in behalf of the Michi-

gan State Medical Society, I wish to present to you, Dr. Reeder, and may God bless you. (Presenting key to Dr. Reeder) (Applause)

DR. FRANK E. REEDER: Mr. Speaker, if this little memento means anything of what little value I may have added to organized medicine during the past twenty-five years, then I am very happy.

It will also make me very happy, as it reminds me over those many years of the many activities, of the many social functions, of the many friendships, which I have had in this legislative body. In fact, I am very happy over the whole thing.

Mr. Speaker, I thank you. I desire to thank my preceptor, Dr. Luce, under whose tutorship I struggled along. One day he said to me, "Reeder, after all, it isn't so hard to make a race horse out of a mule."

I thank you, the House of Delegates. (Laughter and Applause)

DR. LUCE: A question of privilege. Two moments ago I made a motion in this House. I would interpret that as out of order as I am not a member of the House, and to keep the record clear I wish someone else would straighten that out. Kindly accept my apologies. I am so used to talking.

THE SPEAKER: Inasmuch as you were asked to do this by the Speaker and were accorded the privilege of the floor, therefore, you have the right to make a motion. The Chair so rules.

### IX (2). MEMBERSHIP TRANSFERS FROM OTHER STATES

THE SPEAKER: Dr. Leland, there is a question that we would like to put up to you, and that is the question of a member of the Indiana Medical Society—we will take Indiana as an example—who has paid his dues for the year 1938, and then along in the middle of the year transfers to Michigan and desires to become a member of the Michigan State Medical Society and his local county unit. How do we split those dues and through whom do we get it?

DR. LELAND: I am unable to give you the exact ruling adopted in the various amendments to the Constitution and By-Laws of the American Medical Association concerning membership in adjoining county medical societies and state medical societies. However, in general it is a matter of agreement between the two medical societies concerned.

THE SPEAKER: On the question I asked Dr. Leland, we ought to clarify that situation one way or the other. Either we ought to charge that member dues for the balance of that year when he comes into Michigan, or we ought to forget it for that year if he pays the other society.

This subject was discussed by Drs. Ellet, Wenger, Callery, Gruber, Wade, Andrews, C. E. Simpson, the Secretary, O'Donnell, Perkins and Torgerson.

DR. DUTCHESS: Since it is evident that the solution of this question requires some information which is not now available, I move the question be laid on the table.

The motion was seconded by Dr. A. E. Stickley of Ottawa and carried.

## X. RESOLUTIONS

DR. WILLIAM C. ELLET: I have here a resolution I would like to offer.

Dr. Ellet read the Resolution on Nurses' Training Schools.

### X (1). NURSES' TRAINING SCHOOLS

Whereas, Many Nurses' Training Schools have been abolished throughout the State on the advice of Board of Regents of Nurses, and

Whereas, A Resolution was introduced in the House of Delegates at the 1937 meeting asking for guidance and assistance in formulating a plan by which Training Schools for Nurses might be reestablished in the smaller hospitals of this State, and

Whereas, no definite report has been returned to this



House of Delegates as to such action.

Be It Hereby Resolved by the House of Delegates of the Michigan State Medical Society that a Special Committee, with adequate representation from these affected areas be appointed to study this specific problem and return with definite information at the next meeting of Nurses.

THE SPEAKER: This resolution will be referred to the Committee on Resolutions.

#### X (2). EMERITUS AND RETIRED MEMBERSHIPS

Dr. Dutchess read a Resolution submitting for consideration as Emeritus Members the names of Dr. George E. Clark and Dr. Robert W. Gillman.

The Delegates from Wayne County are pleased to submit for consideration as Emeritus members the names of Dr. George E. Clark of Detroit, and Dr. Robert Gillman of Detroit. These two distinguished gentlemen have been elected to Honor membership in the Wayne County Medical Society and their qualifications more than satisfy the requirements of the By-laws of the State Society for Emeritus membership. They have been recommended for this additional honor by The Council of the Wayne County Medical Society.

*Dr. George E. Clark* was born in Norwich, Ontario, 1861. He was graduated from the Detroit College of Medicine in 1888. He has been a member of his local and state medical societies since 1889. He is a general practitioner.

*Dr. Robert W. Gillman* was born in Detroit, 1865. He was graduated from the Detroit College of Medicine in 1887, and has been a member of his local and state medical societies since 1890. His specialty is ophthalmology.

C. E. DUTCHESS, M.D.  
DAVID I. SUGAR, M.D.

THE SPEAKER: This resolution will be referred to the Reference Committee.

A Resolution, submitting the name of Dr. Fred Freeman for consideration as an Emeritus Member, was read by Dr. Clarence E. Toshach of Saginaw.

Whereas, Dr. Fred Freeman has, for more than fifty years, practiced medicine faithfully and honorably with great devotion to his patients.

The Saginaw County Medical Society recommends that he be made a member Emeritus of the Michigan State Medical Society.

THE SPEAKER: This resolution will be referred to the Reference Committee.

A resolution submitting the name of Dr. Joseph Addison Crowell for Emeritus Membership was read by Dr. E. M. Libby of Dickinson-Iron.

The Dickinson-Iron Counties Medical Society wish me to propose the name of Dr. Joseph Addison Crowell of Iron Mountain for Emeritus membership in the Michigan State Medical Society.

Dr. Crowell has practiced medicine in Michigan for fifty-eight years, and has been a member of his county and state medical societies continuously for more than twenty-five years.

E. M. LIBBY, M.D.

THE SPEAKER: This will be referred to the Committee also.

A resolution submitting the name of Dr. E. D. Brooks of Kalamazoo for Emeritus Membership was read by Dr. Fred M. Doyle of Kalamazoo.

Dr. E. D. Brooks of Kalamazoo, Michigan, is recommended by the Kalamazoo Academy of Medicine for Member Emeritus in the Michigan State Medical Society. His qualifications are as follows: B.S., Michigan State College, 1876; Graduate, University of Michigan Homeopathic Medical College, June 23, 1885; Vice President of Hahneman Society during Senior year; began general practice in Flushing, Michigan, 1885; Assistant to chair of Ophthalmology and Otolaryngology, and Assistant Surgeon to Eye, Ear, Nose and Throat of Homeopathic Hospital at University of Michigan, 1894-95; special course in Eye, Ear, Nose and Throat, College of Chicago, 1898; special course in Allgemeines Krankenhaus, Vienna, August to October, 1906; went to Kalamazoo in 1907 and practiced Eye, Ear, Nose and Throat there since. Now practically retired. Eighty-four years of age, September 6, 1938.

A resolution submitting the name of Dr. Harry G. Berry for Emeritus Membership was read by Dr. R. F. Salot of Macomb.

Whereas, Harry G. Berry, M.D., has been a practicing physician in Macomb County for over fifty years, and

Whereas Dr. Harry G. Berry has been a member of the Macomb County Medical Society for over twenty-five years,

Be it hereby resolved that he be made an Emeritus Member of the Michigan State Medical Society.

R. F. SALOT,  
Delegate, Macomb County.

THE SPEAKER: This will also be referred to the Reference Committee on Resolutions.

Resolution submitting the name of John W. Handy for Emeritus Membership was read by Dr. Robert Scott of Genesee.

The Genesee County Medical Society wishes to present the name of John W. Handy, M.D., as Member Emeritus in the Michigan State Medical Society.

Dr. Handy was born October 5, 1852, graduated from the University of Michigan in 1884, and has been a member of the Genesee County Medical Society since 1887.

His name has been voted on favorably for this honor by the Genesee County Medical Society.

Resolution submitting for Emeritus Member the name of Dr. Archibald Blythe Thompson was read by Dr. G. H. Southwick of Kent.

The Kent County Medical Society recommends as a Member Emeritus in the Michigan State Medical Society one of its most highly respected members, Doctor Archibald Blythe Thompson.

Doctor Thompson was born at Blythe, Ontario, seventy-three years ago, and has practiced medicine in Grand Rapids for fifty-one years. He is a graduate of the Royal College of Physicians and Surgeons of Edinburgh and the Faculty of Physicians and Surgeons of Glasgow in the year 1887. Following graduation he came to Grand Rapids where he entered into practice on November the first of that same year. He is a charter member of the Kent County Medical Society and has been active in all its affairs since its beginning in 1902.

The Kent delegation is proud to recommend Doctor Thompson most highly as a Member Emeritus.

#### X (3). PHYSICIANS AND CULTISTS

Dr. C. F. DeVries of Ingham read a resolution regarding consultation with irregular practitioners.

Whereas, organized medicine receives many inquiries concerning the relations of the various cults to the regular profession, particularly pertaining to the osteopath and the optometrist, and

Whereas, members of medical societies are frequently requested to consult with or otherwise associate in a professional capacity with irregular practitioners, and

Whereas, a consultation with a cultist is usually futile and such consultation lowers the honor and dignity of the profession in the same degree to which it elevates the honor and dignity of the irregular practitioner, therefore

Be It Resolved That the House of Delegates of the Michigan State Medical Society regards any voluntary association in other than in an emergency, with irregular practitioners, as unethical.

THE SPEAKER: This will also be referred to the Reference Committee on Resolutions.

#### X (2). RETIRED MEMBERSHIPS

Dr. Perkins of Bay City read a resolution asking Retired Membership for Dr. John Weed.

At a regular meeting of the Bay-Arenac-Iosco-Gladwin Medical Society, held at Bay City, January 8, 1938, the following resolution was passed:

Be It Hereby Resolved—That this Society recommend to the House of Delegates at their next Annual Meeting, that Dr. John Weed of East Tawas, a member of this Society, be granted a Retired Membership in the State Society, according to Section V, Article III of the Constitution.

Dr. Weed has fulfilled the requirement for Retired Membership in the State Society, having been a member of the County and State Societies since entering the practice of Medicine following his graduation from the Michigan College of Medicine and Surgery, March, 1895.

He has always taken an active interest in the affairs of both Local and State Societies. He is now retired from active practice.

Therefore we present to you the name of Dr. John Weed of East Tawas for a Retired Membership in the Michigan State Medical Society, and

We hereby request that his name be inscribed on the Rolls of the State Society as such a Member.

A resolution was read by Dr. J. C. Webster of Huron-Sanilac County asking for Retired Membership for Dr. A. J. Howell.

The Huron-Sanilac County Medical Society wishes to present the name of Dr. A. J. Howell of Bayport, Michigan, for Retired Membership in the Michigan State Medical



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Society. He has had a continued membership from 1920 to 1937, inclusive, and now retired on account of his health.

### X (4). CITIZENSHIP

Dr. William C. Ellet of Berrien County read a resolution on requiring of foreign graduates full citizenship in the United States.

Whereas, The license to practice medicine and surgery in many countries is limited strictly to citizens of these countries; and

Whereas, In addition to holding full citizenship, each applicant is required, in several of these countries, to show that his medical education was pursued and completed in said countries; and

Whereas, Foreign graduates in medicine and surgery, in increasing numbers, are seeking admittance to the practice of medicine in these United States; and

Whereas, In order to convey adequately to these applicants a full and satisfactory knowledge of the American conception of patriotism and of ethical ideals in medicine; it is necessary that a period of residence be required; therefore be it

Resolved, That in addition to the requirements for foreign graduates, as outlined in a resolution adopted by the House of Delegates for the American Medical Association in 1936, it is highly desirable that an additional requirement of full citizenship in the United States of America be demanded; and be it further

Resolved, That the House of Delegates of the Michigan State Medical Society heartily approve and endorse the present rules and regulations of the State Board of Medical Registration, which has enforced the above since 1930.

THE SPEAKER: That particular resolution, I think, is redundant because I am informed the State Board requires it now.

DR. ELLET: I talked with Dr. McIntyre about this today and he would like to have the opinion of this House of Delegates and the State Medical Society backing him up.

### X (5). CHANGE IN COUNCILOR DISTRICTS

Dr. F. J. O'Donnell of Alpena read a resolution referring to the councilor district distribution of counties.

The Thirteenth Councilor District is now composed of the following counties: Alpena, Alcona, Presque Isle, Antrim, Charlevoix, Cheboygan, Emmet. Alpena, Alcona, and Presque Isle Counties are practically one medically under the auspices of the Alpena County Medical Society, while the remainder of the counties—Antrim, Charlevoix, Cheboygan and Emmet—are under the auspices of the Northern Michigan Medical Society.

Believing this distribution to be geographically incorrect and also believing it would be for the best interests of all concerned, including the whole Michigan State Medical Society, be it resolved

"That the members of the Alpena County Medical Society be transferred to the Tenth Councilor District, and the members of the Northern Michigan Medical Society be transferred to the Ninth Councilor District, and that the Seventeenth Councilor District be renumbered the Thirteenth Councilor District."

We offer this for your kind consideration.

THE SPEAKER: This particular resolution is merely confirmatory of one in The Council report and will be referred to the Committee on Resolutions.

### X (2). EMERITUS MEMBERSHIP

Dr. Harvey Hansen of Calhoun read a resolution asking for Emeritus Membership for Dr. George C. Hafford of Albion.

We offer a resolution from the Calhoun County Medical Society urging Emeritus Membership for Dr. George C. Hafford of Albion, graduate of the University of Michigan in 1887, and a member of our County Medical Society for fifty years.

### X (6). MERGER OF DELTA-SCHOOLCRAFT

Dr. O. S. Hult of Delta County read a resolution on merging Delta County and Schoolcraft County Societies.

At the request of Delta County and Schoolcraft County Medical Societies

Resolved that the Delta County Medical Society and the Schoolcraft County Medical Society be merged as one, the combination to be called the "Delta-Schoolcraft Medical Society."

THE SPEAKER: This resolution is also confirmatory to the one which was in The Council report.

### X (7). PROPOSED CONSTITUTIONAL AMENDMENT RE MEMBERSHIP

DR. PERKINS: I move that an amendment be made to Article III, Section 1 of the Constitution of the Michigan State Medical Society, on page 123 of the Handbook.

The motion is that membership in the County Medical Society on a basis not including membership in the Michigan State Medical Society is not recognized. The above amendment to be added to Article III, Section 1, following the words, "and whose local and State dues have been paid."

THE SPEAKER: The amendment is referred to the reference committee and, if approved, will be acted upon next year.

We will now recess.

(Intermission)

### VIII (4). REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

THE SPEAKER: We will now hear from Dr. Insley, Chairman of the Reference Committee on Reports from Standing Committees.

DR. STANLEY W. INSLEY: The Committee wishes to beg your indulgence for the length of time taken in making out this report. I think that you are all aware, of course, of the tremendous amount of detail involved in going through some score of different committee reports, as well as the exhibits and the report itself, dealing with the distribution of medical care. It is a tremendous job, and may I here publicly thank the members of my Committee for all the help in time of need that they have given me, and to this Society.

The Reference Committee on Reports of Standing Committees reports as follows:

#### VIII (4a). REFERENCE COMMITTEE ON LEGISLATIVE COMMITTEE [VI (1)]

Dr. Insley read from his report.

The Reference Committee on Reports of Standing Committees begs to report as follows:

*Legislative Committee*—We recommend the acceptance and adoption of the Annual Report of the Legislative Committee with the exceptions of Paragraph 4 of the Report and No. 3 of the Recommendations, as printed in the "Handbook for Delegates" (Pages 49-51).

DR. INSLEY: I move the adoption of this report.

The motion was seconded by Dr. C. K. Hasley.

THE SPEAKER: Do you want to pass right over, or do you want to look that up and discuss it?

DR. INSLEY: I can elucidate. Paragraph 4 of the Report and No. 3 of the Recommendations had to do with the Welfare Reorganization Referendum which will be held this fall. Now, regardless of the merits for or against this enactment, it was felt unnecessary at the present time to include such items in this particular final report.

THE SPEAKER: Is there any further discussion?

DR. HENRY COOK: As this is worded, I think the Committee is justified in taking its position, but I would like to make this explanation.

The matter of the position of the Michigan State Medical Society in regard to the referendum was left open by The Council and the Executive Committee, and each group was asked to prepare information and arguments both for and against with the understanding that we would take no position but would publish the information as they might prepare it. That is the position.

If nothing is done and we are not allowed to publish this information, it places the Michigan State Medical Society, and I think your agencies which contact them, in a very, very embarrassing position.

We are not asking and do not feel that our profession should take a definite stand because of the difference in opinion, but certainly there can be no reason for stifling the information or keeping it from the profession. Certainly it is justifiable to



present that information as each group may formulate its arguments for the information of the profession, because frequently as we go around among these county societies the doctors ask us what they should do, and we have said that information pro and con would be presented in THE JOURNAL. That I think we should take into consideration in the action.

DR. O. D. STRYKER: I think this whole question will automatically die because I was supposed to contact Mr. Mel McPherson to give the opposing side on the welfare referendum, and he was so confident that the whole set-up would be defeated that he didn't even consider it worth his time or the time of his colleagues to prepare this article for publication in THE JOURNAL.

The time is rapidly drawing to a close. I had thought we would contact him again, but personally, as far as I am concerned, I would say, let the whole matter drop.

THE SPEAKER: All those in favor of the motion signify by saying "aye"; opposed. Carried.

VIII (4b). REFERENCE COMMITTEE ON JOINT COMMITTEE [VI (2)]

Dr. Insley read the report of the Committee on The Representatives to Joint Committee on Health Education.

*The Representatives to Joint Committee on Health Education*—We recommend the acceptance and adoption of the Annual Report of the Representatives to Joint Committee on Health Education, as printed in the "Handbook for Delegates" (pages 52-53). We heartily concur with their recommendations and suggest that they further extend the publication in matters of health instruction to the public in the daily press and to continue their preparation and publication of booklets on mental, personal and social hygiene to be distributed in the public schools.

DR. INSLEY: I move the adoption of this report. The motion was seconded by Dr. Harvey Hansen, put to a vote and carried.

VIII (4c). REFERENCE COMMITTEE ON POST-GRADUATE MEDICAL EDUCATION [VI (6)]

Dr. Insley read the Report on the Committee on Postgraduate Medical Education.

*Committee on Postgraduate Medical Education*—The Committee on Postgraduate Medical Education is to be commended for the large amount of work so effectually consummated during the past year, this work being extended to 15 per cent more practitioners than in previous years.

The question of securing a continuation study center in Detroit was advanced and your Committee believes that further study should be given this matter as suggested by the Committee on Postgraduate Medical Education.

Also approved by the Reference Committee are:

1. Improved methods of interne teaching.
2. Unit system of credits proposed.
3. Addition of the Chairmen of several committees dealing with related subjects (as ex-officio members of the Postgraduate Medical Education Committee).
4. Recommendation for qualifications for certification of physicians attending extramural courses.
5. That the time limit for completion of postgraduate work entitling to certification be not over six years.

The Committee on Postgraduate Medical Education is urged to continue the progress reported in establishing an Endowment Fund for postgraduate education.

We recommend the acceptance and adoption of the annual report of this committee.

DR. INSLEY: I move the adoption of this report.

The motion was seconded by Dr. Louis J. Hirschman and carried.

VIII (4d). REFERENCE COMMITTEE ON PUBLIC RELATIONS COMMITTEE [VI (4)]

Dr. Insley read the Report on the Public Relations Committee.

*Public Relations Committee*—We recommend the acceptance and adoption of the Annual Report of the Public Relations Committee as printed in the "Handbook for Delegates" (Pages 88-90).

DR. INSLEY: I so move the acceptance and the adoption.

The motion was seconded by Dr. C. S. Kennedy, put to a vote and carried.

VIII (4e). REFERENCE COMMITTEE ON CANCER COMMITTEE [VI (7)]

Dr. Insley read the report on the Cancer Committee.

*Cancer Committee*—We recommend the acceptance and adoption of the Annual Report of the Cancer Committee as printed in the "Handbook for Delegates" (Pages 70-71).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. William J. Stapleton, put to a vote and carried.

VIII (4f). REFERENCE COMMITTEE ON MEDICO-LEGAL COMMITTEE [VI (5)]

Dr. Insley read the report on the Medico-Legal Committee.

*Medico-Legal Committee*—We recommend the acceptance and adoption of the Annual Report of the Medico-Legal Committee as printed in the "Handbook for Delegates" (Pages 92-95).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. C. K. Hasley, put to a vote and carried.

VIII (4g). REFERENCE COMMITTEE ON PREVENTIVE MEDICINE COMMITTEE [VI (8)]

Dr. Insley read the report on the Preventive Medicine Committee.

*Preventive Medicine Committee (Its Advisory Committee on Tuberculosis Control and Its Advisory Committee on Syphilis Control)*—Your Reference Committee recommends the acceptance of the printed reports of this Committee and its Advisory Committees ("Handbook for Delegates" Pages 72-79), with the suggestion that postgraduate instruction for physicians interested in the various phases of preventive medicine, as outlined in the reports, be continued. It is further recommended that the other studies mentioned should be continued.

DR. INSLEY: I so move the acceptance and adoption of this report.

The motion was seconded by Dr. A. L. Callery, put to a vote and carried.

VIII (4h). REFERENCE COMMITTEE ON ETHICS COMMITTEE [VI (9)]

Dr. Insley read the report on the Ethics Committee.

*Ethics Committee*—We recommend the acceptance and adoption of the Annual Report of the Ethics Committee as printed in the "Handbook for Delegates" (Page 91).

DR. INSLEY: I so move the acceptance and adoption.

The motion was seconded by Dr. Charles Ten Houten, put to a vote and carried.

VIII (4i). REFERENCE COMMITTEE ON DISTRIBUTION OF MEDICAL CARE [VI (3)]

DR. INSLEY: Now we come to the Report of the Committee on the Distribution of Medical Care. There was a considerable amount of material in the Handbook as well as in the exhibits passed out yesterday. Your Committee felt that the condensation of this material would be very much in order, and so, under certain headings, we have attempted to cover the entire range of that report.



For purposes of convenience, you may start off with so-called Insurance.

Your Committee reports as follows:

Dr. Insley read that portion of the report under the heading "Insurance."

*Insurance*—We approve the principle of Voluntary Hospital Insurance, providing that Hospital Insurance be so defined that it does not include professional services by a Doctor of Medicine.

We also recognize the merits of certain principles in Voluntary Health Insurance, and

We therefore urge that Recommendation IV of the "General Program of Medical Care" as defined by the American Medical Association September 17, be adopted in principle by the Michigan State Medical Society.

We further recommend that the Committee on Distribution of Medical Care continue with more detailed studies of an acceptable insurance program—these studies to be presented to a special meeting of the House of Delegates in the near future.

#### RECOMMENDATION IV—GENERAL PROGRAM OF MEDICAL CARE

"We approve the principle of hospital service insurance which is being widely adopted throughout the country. It is capable of great expansion along sound lines and we particularly recommend it as a community project. Experience in the operation of hospital service insurance or group hospitalization plans has demonstrated that these plans should be confined themselves to provision of hospital facilities and should not include any type of medical care. We recognize that health needs and means to supply needs vary throughout the United States. Studies indicate that the health needs are not identical in different localities, but that they usually depend on local conditions and therefore are primarily local problems. We therefore encourage county or district medical societies with the approval of the State Medical Society, of which each is a component part to develop appropriate means to meet their local requirements. In addition to insurance for hospitalization, we believe it is practicable to develop cash indemnity insurance plans to cover in whole or in part the costs of emergency or prolonged illness. Agencies set up to provide such insurance should comply with state statutes and regulations to insure their soundness and financial responsibility.\* We are not willing to foster any system of compulsory health insurance. We are convinced that it is a complicated bureaucratic system which has no place in a democratic state. It will undoubtedly set up a far reaching tax system with great increase in the cost of government; that it would lend itself to political control and manipulation there is no doubt.

We recognize the soundness of the principles of workmen's compensation laws and recommend the expansion of such legislation to provide for meeting the cost of illness sustained as a result of employment in industry. We repeat our conviction that voluntary indemnity insurance may assist many income groups to finance their sickness costs without subsidy. Further development of group hospitalization and establishment of insurance plans on the indemnity principle to cover the cost of illness will assist in solution of these problems.

DR. INSLEY: I move that these recommendations be adopted.

The motion was seconded by Dr. A. T. Hafford.

THE SPEAKER: Is there any discussion on this motion?

DR. LOUIS J. HIRSCHMAN: I merely wish to call the attention of the House of Delegates to the fact that we did not include Recommendation 5 of the A.M.A. report, not because we were either opposed or in favor of it. In fact the majority of the Committee felt it should not be included at this time merely because we did not want to introduce any more controversial material to cloud the issue as to health and hospital insurance at this time.

I merely wanted to make that remark to show you we did not overlook it.

THE SPEAKER: Are there any further comments on the motion?

The motion was put to a vote and carried.

DR. INSLEY: We next took up the phase of medical aid to the medically indigent.

Dr. Insley read the Report of the Committee

under the heading "Medical Aid to Medical Indigents."

*Medical Aid to Medical Indigents*—A person is medically indigent when he is unable, in the area in which he resides, through his own resources to provide himself and his dependents with proper medical, dental, nursing, hospital care, pharmaceutical supplies and therapeutical appliances without depriving himself or his dependents of necessary food, clothing, shelter and similar necessities of life. The government is responsible for this group.

Any program of medical relief to the indigents should allow for the American system of free choice of physician and the personal patient-physician relationship.

We recommend:

1. That a State Commission of Medical Relief be established whose function shall be purely administrative—this Department to deal only with the medically needy and indigents.

The Director of this Department shall be a graduate in Medicine and legally licensed to practice medicine in Michigan.

2. We also recommend that the study of details on such an indigent plan be referred jointly to the Legislative Committee and to the Committee on Distribution of Medical Care.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. Otto O. Beck, put to a vote and carried.

DR. INSLEY: Next we had to deal with the Medical Finance Service.

Dr. Insley read that part of the report under the heading "Medical Finance Service."

*Medical Finance Service*—We recommend the acceptance and adoption of the report on Medical Finance Service as printed in Exhibit F, and urge that such service be extended throughout the State wherever feasible.

The communications from Dr. Grant James and from Dr. Hubbell were referred to the Committee on Distribution of Medical Care for further study.

Now then—the Committee on Distribution of Medical Care, and especially its Chairman, Dr. Ralph Pino, have done a monumental work in investigation. We feel that a hearty vote of thanks and appreciation should be rendered these gentlemen.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. R. M. McKean, put to a vote and carried.

DR. INSLEY: The last has to do with laboratories.

Dr. Insley read the report on "Laboratories."

*Laboratories*—We recommend the acceptance and adoption of the recommendations set forth in the report on "Laboratories" as printed in Exhibit G.

DR. INSLEY: I move the acceptance and adoption of this report.

The motion was seconded by Dr. Warren B. Cooksey, put to a vote and carried.

DR. INSLEY: The communications from Dr. Grant James and from Dr. Hubbell were referred to the Committee on Distribution of Medical Care for further study.

Now then, the Committee on Distribution of Medical Care, and especially its Chairman, Dr. Ralph Pino, have done a monumental work in investigation. We feel that a hearty vote of thanks and appreciation should be rendered these gentlemen.

I move that this be done.

The motion was seconded by several, including Dr. Hirschman, and carried by rising vote. (Applause.)

DR. HIRSCHMAN: I move the adoption of the report as a whole.

The motion was seconded by Dr. G. H. Southwick, put to a vote and carried.

\*and have the approval of the county and state medical society under which they operate.



THE SPEAKER: Now, Dr. Pino, I think you ought to get up and take a bow.

Dr. Pino arose. (Applause)

And in accordance with that, I think Dr. Insley ought to take a bow, too. (Applause)

THE SPEAKER: Now we will take up new business.

DR. S. L. LOUPEE: I have two brief resolutions. It seems to me that one should have come under Unfinished Business, as a similar one was presented before.

#### X (2). EMERITUS MEMBERSHIP

Dr. Loupee read a resolution recommending the name of John H. Jones for Emeritus Membership.

Cass County Medical Society presents the name of Dr. John H. Jones for Emeritus membership in the State Society.

Dr. Jones graduated from the Medical Department of the University of Michigan more than fifty years ago and has been continuously a member of the County and State Societies for forty-five years or more.

#### X (8) W. C. McCUTCHEON, M.D., DECEASED

Dr. Loupee read a resolution expressing appreciation of the services of Dr. W. C. McCutcheon.

Whereas, Dr. W. C. McCutcheon, late of Cassopolis, Cass County, was throughout his professional life a devout, loyal and faithful member of organized medicine in Michigan.

Whereas, Dr. McCutcheon fell victim to a deadly attack of coronary thrombosis while in attendance at the yearly meeting of the House of Delegates at Grand Rapids in 1937, therefore

Be it resolved, that special mention be made of the services of Dr. McCutcheon and that the Secretary enter this resolution upon the minutes of this meeting.

And be it further resolved, that a copy of this be sent to his family, as an expression of the esteem in which Dr. McCutcheon was held by the House of Delegates and the doctors of the Michigan State Medical Society.

THE SPEAKER: These will be referred to the Committee on Resolutions.

Is there anything else under the head of New Business to come at this session?

DR. LOUIS J. HIRSCHMAN: I move we recess until eight o'clock.

The motion was seconded and carried and the meeting recessed at five forty-five o'clock.

### Monday Evening Session

September 19, 1938

The meeting was called to order at eight-thirty o'clock, Speaker Riley presiding.

THE SPEAKER: The Third Session of this meeting will now come to order.

We will have a report from the Credentials Committee.

The report of the Credentials Committee is that we have seventy-seven delegates here.

There is a motion made and seconded that seventy-seven delegates constitute the roll call of the House. All those in favor signify by saying "aye"; opposed. It is carried.

#### VIII (5). REFERENCE COMMITTEE ON RESOLUTIONS (X)

THE SPEAKER: Dr. Reeder, Chairman of the Reference Committee on Resolutions, will report.

#### VIII (5a) REFERENCE COMMITTEE ON EMERITUS AND RETIRED MEMBERSHIPS [X (2)]

DR. FRANK E. REEDER: Mr. Speaker and Members of the House: Your Reference Committee on Resolutions reviewed the resolutions as presented, and we now desire to offer them for your disposal.

The following names were offered by resolution for Membership Emeritus:

Dr. George E. Clark of Wayne

Dr. Fred Freeman of Saginaw

Dr. Joseph Crowell of Dickinson-Iron

Dr. E. D. Brooks of Kalamazoo

Dr. Harry G. Berry of Macomb

Dr. John W. Handy of Genesee

Dr. Archibald Thompson of Kent

Dr. George Hafford of Calhoun

Dr. John H. Jones of Cass

Dr. Robt. W. Gillman of Wayne

All of these gentlemen having fulfilled the qualifications necessary for Membership Emeritus, Mr. Speaker, I move the adoption of the resolutions for these gentlemen to Membership Emeritus in the Michigan State Medical Society.

The motion was seconded by Dr. Robb and carried.

DR. REEDER: Mr. Speaker, the following two men were recommended by resolution for Retired Membership:

Dr. John Weed of Bay-Arenac-Iosco-Gladwin.

Dr. A. J. Howell of Huron-Sanilac

Having fulfilled the qualifications, Mr. Speaker, I move the adoption of the resolutions for their membership.

The motion was seconded by Dr. Donald R. Brasic and carried.

#### VIII (5b). REFERENCE COMMITTEE ON DR. McCUTCHEON [X (8)]

DR. REEDER: Mr. Speaker, the resolution pertaining to Dr. W. C. McCutcheon, late of Cassopolis, Cass County, was as follows:

Dr. Reeder read the resolution. (See page ..)

I move the adoption of this resolution.

The motion was seconded by Dr. O'Donnell and carried.

#### VIII (5c). REFERENCE COMMITTEE ON PHYSICIANS AND CULTISTS [X (3)]

DR. REEDER: Mr. Speaker, a resolution was offered pertaining to the relation of physicians and cultists, as was outlined in the *Journal of the A.M.A.*, April 30, 1938. The resolution is as follows:

Dr. Reeder read the resolution.

Physicians and Cultists—Many inquiries concerning the relations of the various cults to the regular profession have been received. The inquiries pertain particularly to the osteopath and the optometrist. Some of our members are giving lectures in osteopathic and optometric schools and addresses before their societies. Some members are associated by a common waiting room in offices with them. Some members are by mutual agreement professional associates principally in the field of surgery. There are some instances of partnership in practice. All of these voluntarily associated activities are unethical. Such relations certainly do not "uphold the dignity and honor of (our) profession" or "exalt its standards." In case of emergency no doctor should refuse a sufferer knowledge or skill which he possesses to the sufferer's harm but this is quite a different matter from that of a consultant or practitioner who by consulting or practicing with him assists a cultist to establish himself as competent and on the same basis of medical knowledge as a doctor of medicine. By the very nature of the education and training of each, a consultation with a cultist is a futile gesture if the cultist is assumed to have the same high grade of knowledge, training and experience as is possessed by the doctor of medicine. Such consultation lowers the honor and dignity of the profession in the same degree to which it elevates the honor and dignity of the irregular in training and practice. Practicing as a partner or otherwise has the same effect and objection. Teaching in cultist schools and addressing cultist societies is even more reprehensible, for such activities give public approval by the medical profession to a system of healing known to the profession to be substandard, incorrect and harmful to the people because of its deficiencies. There hardly can be a voluntary relationship between a doctor of medicine and a cultist which is ethical in character.

Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. Wenger, put to a vote and carried.

#### VIII (5d). REFERENCE COMMITTEE ON CITIZENSHIP [X (4)]

DR. REEDER: Mr. Speaker, a resolution pertaining to the requiring of foreign graduates having full citizenship in the United States:

Dr. Reeder read the resolution. (See page 1027.)



Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. H. W. Wiley.

THE SPEAKER: Is there any discussion?

DR. BRASIE: I have one query. Is there anything in this resolution that prevents exchange fellowships between our universities and the universities of England, for instance, such as has occurred in the past between the University of Michigan and the St. Bartholomew School in England?

DR. ELLET: I might say that when this question came up, that was the first thing that entered my mind. I talked with Dr. McIntyre about it, and these men are not considered as practicing medicine. They have been and will continue to be granted every right that we would have.

DR. E. D. SPALDING: May I suggest that this be temporarily tabled and we come back to it?

THE SPEAKER: Your suggestion will be followed.

#### VIII (5e). REFERENCE COMMITTEE ON NURSES' TRAINING SCHOOLS [X (1)]

DR. REEDER: A resolution pertaining to Nurses' Training Schools:

Dr. Reeder read the resolution. (See page 1025.)

Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. R. E. Spinks and carried.

DR. REEDER: Mr. Speaker, with the exception of the resolution which was temporarily tabled, that completes our report, and with that exception, I move, sir, the adoption of the Report of the Committee as a whole.

The motion was seconded by Dr. Ralph Pino and carried.

THE SPEAKER: Now, with that exception, you will be excused for a few minutes, Dr. Reeder, until we get Dr. McIntyre up here and then we will take up the other resolution again.

#### VIII (6). REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

We will take up Dr. Torgerson's report.

#### VIII (6a). REFERENCE COMMITTEE ON CHANGE IN COUNCILOR DISTRICTS, AND MERGER OF DELTA-SCHOOLCRAFT [X (5 and 6)]

DR. WILLIAM R. TORGERSON: Mr. Speaker and Delegates: There were two resolutions proposed this afternoon that should have been proposed as By-Laws. They can be considered together because they have the effect of reallocating certain counties in regard to their councilor districts.

The first one has to do with putting together in one organization Delta and Schoolcraft County Medical Societies to be known as the Delta-Schoolcraft County Medical Society.

The second one has to do with a reallocation of the counties now in the Thirteenth Councilor District. The members of the Alpena County Medical Society in that district will be transferred to the Tenth Councilor District, and the members of the Northern Michigan Medical Society will be transferred to the Ninth Councilor District. This would mean the present Thirteenth Councilor District would be no longer in existence, so the Seventeenth Councilor District is renamed the Thirteenth and the Seventeenth is cancelled.

That means the By-Laws would be changed as follows: In Chapter 5, under "The Council," Section 12, the First District, Second District, Third District, Fourth District, Fifth District, Sixth District, Seventh District, and Eighth District will be left as they are:

District Nine will read as it is at present, with the addition of the Northern Michigan Medical Society, which includes Antrim, Charlevoix, Cheboygan and Emmet.

District Ten will read as at present, with the

addition of Alpena, Alcona and Presque Isle Counties.

District Eleven will be as it is.

District Twelve will read Chippewa-Mackinac, Delta-Schoolcraft, Luce, Marquette-Alger.

District Thirteen will include the counties at present in District Seventeen, and District Seventeen will be abolished.

I move that these two amendments be passed at this time as they have been read.

The motion was seconded by Dr. C. S. Kennedy and carried.

THE SPEAKER: Now, to make this legal this has to go over from one session to another, so we will have a recess, if someone will make a motion for a recess, of one minute and reconvene and take it up again, and it will be legal.

Will someone make a motion to recess?

DR. R. L. FINCH: I move we recess.

The motion was seconded by Dr. Umphrey and carried.

THE SPEAKER: We are now recessed for about one minute.

(Recess)

THE SPEAKER: We are now called back into session. The second evening session is now open.

I would like a report from the Credentials Committee.

THE SECRETARY: I hold in my hand the credentials of seventy-eight registered delegates, and move that they constitute the roll call of this session.

The motion was seconded by Dr. William J. Stapleton.

The motion was carried.

THE SPEAKER: Dr. Torgerson, will you make your report?

DR. GRUBER: Mr. Chairman, I move that the matter of amending the By-Laws be taken from the table.

THE SPEAKER: There is a motion before the House that the resolution be taken from the table. Is there a support to it?

The motion was seconded by Dr. Clinton, put to a voted and carried.

DR. TORGERSON: I move that the By-Laws be amended as outlined before this was laid on the table.

The motion was seconded by Dr. A. E. Catherwood, put to a vote and carried.

#### VIII (6b). REFERENCE COMMITTEE ON PROPOSED CONSTITUTIONAL AMENDMENT ([X (7)])

DR. TORGERSON: Mr. Speaker, there was also an amendment to the Constitution introduced today, in which Article III is to be amended as follows:

Article III, Section 1, now reads:

"This Society shall consist of active members, honorary members, associate members, retired members, and members emeritus. Members shall be members of Component County Societies who have been certified to the Secretary of this Society and whose local and State dues have been paid."

The amendment was to add at the end of that sentence, the sentence:

"Membership in the County Medical Society on a basis not including membership, in the Michigan State Medical Society is not recognized."

It was the opinion of the Reference Committee that the Constitution as it is at present provides that one cannot be a member of the local county unit without being a member of the State Society, when it sets forth in Article III, Section 2, "Qualifications": "Active members shall comprise all the active members of a component county society." For this reason, we thought this amendment was superfluous, and did not recommend its being considered. However, a vote on it will have to be taken at the next meeting, I believe next year.



I move it be laid over until next year to be voted on at that time.

The motion was seconded by Dr. Stapleton and carried.

THE SPEAKER: Is there any further Unfinished Business?

## XI. ELECTIONS AND PLACE OF ANNUAL MEETING

We will now conduct the elections of the Society.

I will appoint four tellers: Dr. Novy, Dr. Finch, Dr. Wenger and Dr. Kennedy.

### XI (1). COUNCILOR OF ELEVENTH DISTRICT

The first election to be held is that of Councilor of the Eleventh District to succeed Roy H. Holmes, M.D., of Muskegon. Nominations are now in order.

DR. E. O. FOSS (Muskegon): Mr. Speaker, I want to nominate a man who has been attending for the last three years, a man who has been very dynamic in his work. I nominate Dr. Roy Holmes.

THE SPEAKER: Dr. Roy Holmes has been nominated. Is there a second?

The nomination was seconded by Dr. E. N. D'Alcorn of Muskegon.

THE SPEAKER: Are there any other nominations?

Remember, nominations for councilor must be made by the delegates from that councilor district.

If there are no other nominations will someone kindly move that the nominations be closed?

DR. FOSS: I move the nominations be closed and the unanimous vote of this assembly be cast for Dr. Holmes for Councilor.

The motion was seconded by Dr. Snapp, put to a vote and carried unanimously.

THE SPEAKER: Mr. Secretary, will you cast the unanimous ballot for Dr. Holmes.

THE SECRETARY: I have so cast.

### XI (2). COUNCILOR OF TWELFTH DISTRICT

THE SPEAKER: The next election is that of Councilor of the Twelfth District to succeed F. C. Bandy, M.D., of Sault Ste. Marie.

DR. E. S. SCOTT (Chippewa-Mackinac): I would like to nominate Dr. F. C. Bandy to succeed himself.

THE SPEAKER: Dr. Bandy has been nominated. Do I hear a second?

The nomination was seconded by Dr. R. E. Spinks of Luce County.

DR. JAMES H. FYVIE (Schoolcraft): I nominate C. D. Hart, M.D., of Luce County.

The nomination was seconded by Dr. Brasie.

DR. HARVEY HANSON: I move the nominations be closed.

The motion was seconded and carried unanimously.

THE SPEAKER: The tellers will pass the ballots and you may vote on these nominees.

The ballots were cast and counted.

THE SPEAKER: I now declare Dr. Hart elected Councilor.

### XI (3). COUNCILOR OF NEW THIRTEENTH DISTRICT

Nominations are in order for a councilor to succeed Dr. W. A. Manthei of Lake Linden.

DR. G. M. WALDIE (Houghton): I place in nomination Dr. W. A. Manthei, who has served this District as Councilor since its organization some seven years ago.

THE SPEAKER: Are there any other nominations?

DR. MANTHEI: I would like to have my name withdrawn from the list of candidates, if there is a list, because I think I have served my time, and

besides that, that district is the wrong number now. I am not a candidate for re-election. (Laughter)

THE SPEAKER: Are there any other nominations?

DR. S. C. MASON (Menominee): I would like to present Dr. W. H. Huron of Iron Mountain.

The nomination was seconded by Dr. Vivian Vandeventer.

DR. E. M. LIBBY: I move the nominations be closed, and the Secretary cast the unanimous ballot.

The motion was seconded by Dr. Wenger and carried unanimously.

The ballot was cast by the Secretary.

THE SPEAKER: As the result of an automobile accident, Dr. Bandy is in the hospital at Grayling and so is Dr. Rhind, the delegate from Chippewa. I think a motion from this body to send a message of condolence to these men and their families, and possibly a few flowers, would be in order now.

DR. ROBB: I so move.

The motion was seconded by several and carried.

THE SPEAKER:

### XI (4). DELEGATES TO A.M.A.

We will now pass on to the election of delegates to the American Medical Association. We will elect these delegates one by one tonight.

The first one is to succeed Dr. Henry Luce.

DR. DUTCHESS: How long the man whom I wish to nominate has been serving organized medicine, I don't know. I do know that in 1925 I saw him conduct the Council of the Wayne County Society week after week, and I never ceased to admire his ability as presiding officer, his industry, and his devotion to the County Society.

He went to the State meeting as a delegate. The years rolled by. In 1931, in the House of Delegates of the A.M.A. at Philadelphia, happening to be present as a guest, I saw him represent Michigan in a spirited contest, brilliantly and successfully. He was then serving not only Wayne County and Michigan State but American Medicine.

Again the years roll by. Just the other day I saw in the paper that he was leading the fight of the Michigan delegates to introduce new business in the House of Delegates at A.M.A. in Chicago.

As you all know, this is a critical time, and at such a time I feel it a great privilege as Chairman of the Wayne Delegation to nominate Dr. Henry Luce as Delegate to the A.M.A.

The nomination was seconded by Dr. Spalding.

THE SPEAKER: Dr. Luce has been nominated and supported. Are there any other nominations to succeed Dr. Henry Luce?

DR. INSLEY (Wayne): I move the nominations be closed, and the Secretary cast the ballot to elect Dr. Luce.

The motion was seconded by R. A. Springer and carried unanimously.

The ballot was cast by the Secretary.

THE SPEAKER: The next delegate to be elected is the delegate to succeed Dr. Thomas K. Gruber.

DR. LOUIS J. HIRSCHMAN: I believe these are critical times, and it is very, very poor policy at a time like this to change horses in midstream. The value of a delegate to his State Society is gathered by his repeated return and his reported contacts with the delegates of other states.

It gives me great pleasure to place in nomination a man to succeed Dr. Gruber, a man we all know and admire, Dr. Thomas J. Gruber of Wayne.

DR. SPALDING: I would like to second this nomination and call to your attention the fact that at a recent meeting of the A.M.A. in San Francisco, Dr. Gruber introduced a resolution on the floor to establish a Public Relations Committee to assist Dr. Fishbein in handling that problem for the A.M.A.

DR. PERKINS: I move the nominations be closed and the Secretary cast the unanimous ballot for the re-election of Dr. Gruber.



The motion was seconded and carried and the ballot was cast by the Secretary.

THE SPEAKER: Dr. Gruber has been re-elected.

This, gentlemen, is Dr. Hart, your new Councilor. (Applause)

DR. HART: Thank you, gentlemen. It is a privilege, and I realize the honor you have bestowed on me. I assure you I shall do my best to work for the doctors of the Twelfth District and the Upper Peninsula and for organized medicine. (Applause)

THE SPEAKER: The next delegate to be elected is one to succeed Dr. Jacob D. Brook. Nominations are now open.

DR. WENGER: Gentlemen, it gives me great pleasure to bring to you one who has been long in your service. He was the President of his County Society for over twenty years, in fact, their representative in this body. From here he went to the A.M.A. and was there over twenty years as a representative. He is a Past President of this organization. It gives me great pleasure to present Dr. J. D. Brook to succeed himself.

The nomination was seconded.

THE SPEAKER: Are there any other nominations?

DR. ROBB: There is a man who has served this Society through a great many years and under very exasperating and exacting circumstances. He has been a member of this organization for twenty-eight years. He served as Speaker of this House for two years. He has never failed, in my knowledge, to serve with unusual ability.

I feel bad that Dr. Sheets of Eaton Rapids is not here to handle this, because he knows really how to put it on and he could describe this man perfectly.

Dr. Frank Reeder has served this organization unusually well. Unfortunately, a short time ago he did not feel well. Tony is now in excellent shape, and I know that he will serve you well. I place in nomination a man who is a prince of good fellows and has promised that he will carry on, as he always has, to the fullest extent for organized medicine—the name of Dr. Frank Reeder.

THE SPEAKER: Dr. Reeder has been nominated. Is there a second?

DR. BRASIE: It gives me very great personal pleasure to second the nomination of Dr. Frank E. Reeder, a man respected by this State Society, and not only respected but loved for all his fine sterling qualities by his own Society of Genesee. I second the nomination.

DR. BROOK: May I have the privilege of the floor?

THE SPEAKER: Yes.

DR. BROOKS: Members of this House of Delegates: Just a word of explanation. I am sorry there was a misunderstanding this morning, or this afternoon, in regard to the report of the Delegates to the A.M.A. I prepared a supplementary report to the one which was printed in the Handbook, and I also prepared a report of the Chicago session. In the forenoon there was not opportunity given to present this report, and then it was found that Dr. Luce was to give a stenographic report of the Chicago convention in the afternoon, which, of course, would be much superior to what anyone would write about that special Chicago session.

For thirty-six years that I have been a member of the State Medical Society, you have seen fit to honor me in various capacities. You have elected me President and Speaker of the House, and for twenty-three years you have elected me Delegate to the American Medical Association. I have attended all of those meetings and two special sessions. For all of these honors, I am extremely grateful and thankful to the Society.

But all things have an end, and I think I have served my apprenticeship, and therefore, I desire

that my name be withdrawn. I am not a candidate for Delegate to the American Medical Association. I would, if I had the power, like to make the motion to make unanimous the election of Dr. Reeder, but I am not a delegate to this House and cannot do it. Thank you again. (Applause)

THE SPEAKER: With the permission of the one who made the nomination and the seconder, that is withdrawn. Is that all right?

It was agreed.

Are there any other nominations?

DR. R. M. McKEAN: I move the nominations be closed and Dr. Reeder elected unanimously, and that Dr. Brooks' very fine action in retiring from this slate be commended.

The motion was seconded by Dr. Wenger, put to a vote and carried unanimously.

THE SPEAKER: Gentlemen, our Ex-President, Dr. Henry E. Perry. (Applause)

Will you come forward, Dr. Perry, and let them all take a look at you and see how good-looking you are?

Dr. Perry was escorted to the platform.

THE SERGEANT-AT-ARMS: Mr. Speaker, I would like to present to you Dr. Henry E. Perry, Past President of the Michigan State Medical Association. (Applause)

DR. HENRY PERRY: Mr. Speaker and Gentlemen: I always thought Dr. Phil Riley was a friend of mine, but I was sitting down in the President's room having a rest and Phil sent the Sergeant-at-Arms down to bring me up here. You know, last Saturday I was getting ready to come down here and left home this morning at seven o'clock and met a couple of my friends, and they said, "Are you going down to Detroit Monday?" I said, "Yes." They said, "Why, I thought you were all through with that medical stuff." I said, "No, I will never get it out of my system, as long as the same old gang is down there, the best bunch of fellows in the State of Michigan. Whenever I have a chance to see them, I am going to see them." I am very glad to be with you tonight, gentlemen, and I thank you. (Applause)

THE SPEAKER: Dr. Perry, you are not half as glad to be here with us as we are to have you here. We certainly miss you at the conventions when you are unable to come and we are always glad to have you with us.

DR. REEDER: Just a few minutes ago you listened to a very splendid talk. In view of that and in view of the many, many years of his service, I think it would be only fitting and proper that the House of Delegates vote a suitable emblem to Dr. Brooks. I so move.

The motion was seconded by Dr. R. L. Novy and carried.

THE SPEAKER: We will continue with the elections.

The next delegate to be elected is the Delegate to succeed Dr. Claude R. Keyport of Grayling. Nominations are now in order.

DR. A. E. CATHERWOOD: I would like to place the name of Dr. Keyport in nomination to succeed himself as delegate to the A.M.A.

The nomination was supported by Dr. O'Donnell.

THE SPEAKER: Are there any further nominations?

DR. C. S. KENNEDY: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for the election of Dr. Keyport.

The motion was seconded by Dr. Louis J. Hirschman, put to a vote and carried, and the Secretary cast the ballot.

#### XI (5). ALTERNATE DELEGATES TO A.M.A.

THE SPEAKER: We will now move on to the nominations of alternate delegates.

The first is one to succeed Dr. T. E. DeGurse.



DR. WILLIAM R. CLINTON: I would like to nominate a man who has been around here many years and has always done what he is supposed to do. I would like to see him have a chance to be Sergeant-at-Arms at A.M.A. That is Dr. J. J. O'Meara.

The nomination was seconded by Dr. Hirschman.

DR. ROBB: I move the nominations be closed and the Secretary be instructed to cast the ballot.

The motion was seconded by Dr. A. L. Callery, put to a vote and carried.

The next alternate to be elected is to succeed Dr. C. S. Gorsline of Battle Creek. Nominations are now in order.

DR. HARVEY HANSEN: I would like to nominate Dr. Gorsline to succeed himself.

The nomination was seconded by Dr. Robb.

THE SPEAKER: Are there any other nominations?

DR. C. K. HASLEY: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot.

The motion was seconded by Dr. Torgerson and carried.

The Secretary cast the ballot.

THE SPEAKER: The next is the Alternate to succeed Dr. R. H. Denham.

DR. SNAPP: I should like to place in nomination the name of Dr. R. H. Denham to succeed himself.

The nomination was seconded by Dr. Wenger of Kent.

THE SPEAKER: Are there any other nominations?

DR. TORGERTSON: I move the nominations be closed.

The motion was seconded by Dr. Southwick and carried.

#### XI (6). PLACE OF ANNUAL MEETING

THE SPEAKER: Grand Rapids boys stuck to it pretty well on that last election, and they also sent in an invitation for us to go to Grand Rapids for our next meeting. We got the invitation in two or three forms from organizations up there. I think that is the only invitation we have. Will someone make a motion that we travel to Grand Rapids next year?

DR. HIRSCHMAN: I move we hold our convention in Grand Rapids next year.

The motion was seconded by Dr. Wenger and carried unanimously.

THE SPEAKER: It is Grand Rapids next year.

#### XI (7). PRESIDENT-ELECT

Now we come to the election of a President-Elect. Nominations are now in order.

DR. GROVER C. PENBERTHY: Mr. Speaker, Dr. Perry, Officers and Members of the House of Delegates: It is a pleasure for me, as a member of the Wayne County Delegation, to present to you the name of a gentleman who has been active in organized medicine for some thirty-odd years. I think the record will show that he took part in the establishment of the first postgraduate clinic to be founded in this state. He has followed through in all this program of medicine. He has served as a member of The Council for many years, and acted as Secretary of the State Society.

During this session we have listened to the problems that we as doctors face, and it requires the action and advice and the guidance of someone who has had experience. We are all delighted to think that next year we are to have as our President, Dr. Luce.

It gives me great pleasure to present the name of Dr. Burton R. Corbus of Grand Rapids as President-Elect. (Applause)

THE SPEAKER: Dr. Corbus has been nominated.

DR. TORGERTSON: It gives me great pleasure, as a member of Kent County Medical Society, to second the nomination of Dr. Corbus.

THE SPEAKER: Are there any other nominations?

DR. ELLET: I move the nominations be closed and the unanimous ballot be cast for Dr. Corbus.

The motion was seconded by Dr. Robb, put to a vote and carried unanimously.

THE SPEAKER: Dr. Corbus will please come forward. (Applause)

THE SERGEANT-AT-ARMS: Mr. Speaker, I would like to present to you Dr. Corbus.

DR. BURTON R. CORBUS: Mr. Speaker and Members of the House of Delegates: As Chairman of the Council and as Acting Secretary, I have in the past had the privilege of standing on this platform and talking to you, but I never have been quite so perturbed and so emotionally upset as I am now. To be acclaimed President-Elect rather than elected is indeed a very great honor, and I feel that it indicates a friendliness which I cherish and which is itself indicative that you have that confidence in me which I hope I can justify. It gives me courage to help you to meet the problems which are going to be serious. There are going to be large problems in these next two years, and it gives me confidence, because since you know me well you must know my weaknesses, and if you think I have the ability to help you and to help this Society during the next two years, I must have it.

There are those who demand that we junk the old model with which we have practiced medicine in these last one hundred years and take on a new streamline chariot which the advocates claim will carry the multitude more safely and more comfortably. But there are a great many parts in the old model which are not yet outworn, and there is a lot of it that must be saved. There is a greatness in the old model with which we have practiced medicine that we can't afford to lose, and in any event, to give a bit of a lighter note to this, we will certainly not be at all influenced by the suggestion which is found in the old Chinese proverb. It goes somewhat like this: She is a wise virgin who, when rape is inevitable, accepts the situation with enjoyment. (Laughter and Applause)

THE SPEAKER: We have a By-Law which has caused us a lot of trouble every year when we try to abide by it. In the years gone by we always got into a jam. This year we elected these alternates individually to avoid that jam, and now I guess we are in a jam with the By-Laws anyway.

The By-Laws read: "Alternate delegates at large so elected shall have relative seniority according to the respective numbers of votes received by them, and such seniority rank shall be designated at the time of election."

We have to designate the seniority rank of the alternate delegates. I think if someone will make a motion to put three numbers in the hat—1, 2, 3—and we draw them out in the order in which we elected them tonight and see which one will be 1, 2, or 3, that would solve it. Will someone make a motion to that effect?

DR. CLINTON: I move we do that.

The motion was seconded by Dr. Hansen of Calhoun.

DR. SPALDING: Mr. Speaker, I appreciate your motives, and I trust the audience will appreciate mine, but the By-Laws are a little more specific than that.

THE SPEAKER: Will someone offer a solution to the problem?

DR. SPALDING: Follow the By-Laws.

THE SPEAKER: Everyone was elected unanimously, so the vote is the same, and we have to decide at the time of the meeting.

DR. SPALDING: The solution could be made by passing ballots and having each man write the three names and a number after each name in the order he wishes them to rank.

DR. WENGER: I move the rules be suspended and



we solve the problem by drawing numbers from the hat.

DR. SPALDING: I rise to a point of order. Unfortunately, although you can suspend the rules of action of the meeting, you cannot suspend the By-Laws.

THE SPEAKER: It doesn't say in the By-Laws how they shall be designated, so your motion is in order.

The motion was seconded and carried.

THE SPEAKER: Dr. Holmes, will you come up and hold the hat? Dr. Finch will draw them out.

The names were drawn from the hat.

THE SPEAKER: The first name out is Alternate No. 1.

The names were drawn in the following order:

(1) Dr. Denham; (2) Dr. O'Meara; (3) Dr. Gorsline.

THE SPEAKER: Mr. Vice Speaker, will you please take the chair.

Dr. Martin H. Hoffmann, Vice Speaker, took the chair.

#### XI (8). SPEAKER

THE VICE SPEAKER: The next order of business is the election of a Speaker of the House of Delegates. The chair will now receive nominations.

DR. LOUIS J. HIRSCHMAN: May I have the distinguished privilege and honor of nominating for the office of Speaker for the coming year Dr. Phil A. Riley of Jackson.

The nomination was seconded by Dr. Kennedy.

THE VICE SPEAKER: The name of Dr. Phil Riley has been placed in nomination for Speaker. (Applause)

DR. SPALDING: I move the nominations be closed and the Secretary instructed to cast the unanimous ballot for the election of Dr. Riley.

The motion was seconded by Dr. H. F. Dibble and carried unanimously.

Dr. Riley resumed the chair.

THE SPEAKER: Gentlemen, I am overwhelmed with surprise.

#### XI (9). VICE SPEAKER

We will have nominations for Vice Speaker of the House of Delegates.

DR. REEDER: I desire to nominate Dr. Martin H. Hoffmann for Vice Speaker.

The nomination was seconded by Dr. O'Donnell.

DR. BRASIE: I move that the nominations be closed and the unanimous ballot be cast for Dr. Hoffmann.

Motion was seconded and carried unanimously.

THE SPEAKER: Dr. Hoffmann is elected Vice Speaker.

Is there anything to come under the head of Unfinished Business?

Is there anything to come under the head of New Business or Unfinished Business?

DR. GROVER C. PENBERTHY: We have listened to the report of the delegates to Chicago at the A.M.A. I would like to move, Mr. Speaker, that a vote of thanks be given to the officers of the State Society who have participated in this activity, as well as the delegates to the A.M.A., and to Dr. Pino and Dr. Insley, who have done a good job in trying to clarify in the minds of all of us a responsibility that rests with the medical profession.

I move that a vote of thanks be given to that group who helped to iron out the problems for the Michigan State Medical Society and the other Society.

I understand from Dr. Luce that the Michigan delegation played a big part in the proceedings at Chicago. I think that reflects the work of Dr. W. H. Marshall, who instituted the movement to carry on a survey and the action that has been carried through with the other Society officers for the past five years.

The motion was seconded by Dr. Catherwood and carried.

#### VIII (5d). REFERENCE COMMITTEE ON CITIZENSHIP [X (4)]

THE SPEAKER: Will Dr. McIntyre and Dr. Reeder come forward?

Dr. Reeder, will you continue with your report?

DR. REEDER: Mr. Speaker. Dr. McIntyre, when I present the resolution, as submitted to the Reference Committee on Resolutions, pertaining to the requiring of foreign graduates full citizenship in the United States, a question was raised by one of the delegates in reference to how this applied to the exchange of fellowships with the universities of foreign countries. No one was able to answer, so we had to send out a messenger for you. I, therefore, at this time, would like to have you answer to the House that question.

DR. J. E. MCINTYRE: The matter of the exchange of professors of the foreign schools was arranged two years ago in June. That is declared to be the non-practice of medicine. There is no objection to the exchange of professorships with any of the foreign schools that are recognized and accepted by the University of Michigan and the College of Medicine of Wayne University, because they are not considered as practicing medicine. The work is simply didactic and for lecture purposes.

This became effective by the Michigan State Board of Medicine in 1930. The first citizenship papers were required and one year of work as a full-time attendant, passing work in a Class A school of medicine in the United States, and one year of approved internship in a hospital approved for internship.

In October, 1935, the requirement was raised to complete citizenship, and two years ago, at a meeting of the State Board of Medicine in Ann Arbor, the matter came up and was presented by a committee of the faculty at the University of Michigan, and that was a satisfactory arrangement for the exchange of professorships.

Does that answer your question, Mr. Speaker?

THE SPEAKER: I believe it does.

DR. REEDER: Mr. Speaker, I move the adoption of the resolution.

The motion was seconded by Dr. Brasie, put to a vote and carried.

DR. REEDER: Mr. Speaker, I move the adoption of the report of the Committee as a whole.

The motion was seconded by Dr. Clinton, put to a vote and carried unanimously.

THE SPEAKER: We have a guest in the House, in the person of the Health Commissioner of the State. I would like to have him come forward and take a bow. Dr. D. W. Gudakunst! (Applause)

Dr. Gudakunst came forward and bowed.

THE SPEAKER: Is there anything to come up under Unfinished Business?

DR. BRASIE: I move that the House of Delegates extend its thanks and appreciation to Wayne County Medical Society for the entertainment they have provided and are about to provide.

The motion was seconded by Dr. Torgerson, put to a vote and carried.

## XII. ADJOURNMENT

THE SPEAKER: I want to take the privilege of expressing my personal appreciation of the interest of the delegates and their attendance and of the work of those who served on Reference Committees. They did noble work.

Upon motion, regularly made and seconded, the meeting adjourned at ten o'clock. Subject to the call of the Speaker in pursuance with the adoption of report of Reference Committee on Standing Committees (Committee on Distribution of Medical Care).



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EXPANSION OF HEALTH SERVICES

"One of the real problems confronting the practicing physician in providing adequate medical care is Michigan's need for extensive diagnostic laboratory services," declared Dr. Don W. Gudakunst, State Health Commissioner, in his address recently on "New Developments in Planning for Public Health and Medical Care" before the annual Conference of Social Work at Lansing.

Modern medicine cannot depend on the unaided five or six senses of the physician, he continued. The day has passed when the entire armamentarium of the doctor could be carried in his little black bag. This black bag today has come to be more of a badge, a symbol, rather than a thing of real service. The diagnostic laboratories call for structures of brick and mortar backed by huge sums of money for the purchase of equipment and employment of a technical staff. It is here the science of medicine is to be found, impersonal, accurate and expensive. It is science serving art. This is one place the state can step in and help unsnarl the tangle of social and financial difficulties.

In Michigan it is hoped that within the year we can add throughout the state additional laboratory services for those unable to pay for or procure such adjuncts to the art of medicine. In areas where laboratories do not exist we hope to build with the assistance of federal funds new buildings and to equip and staff them so that there can be better medical care at no increased cost to the people through the medium of the practicing physician. Where there are already existing laboratories large enough to meet the needs we have a different problem. In such places it is a universally admitted fact that such scientific diagnostic aids are not available to any save the comparatively economically secure. Governmental subsidies granted to such laboratories will enable them to expand, to render care to more nearly the entire population.

But this is only an example of the planned expansion and development of public health. It must be of concern to the health officer that people die of preventable or postponeable causes, other than the communicable diseases. He must be concerned with these causes of death and with the factors contributing to their operation. It is most readily seen that of all the factors so contributing to lack of medical care there are two of great importance—poverty and ignorance. These are not the only factors, but we feel they are not only the most important but also the two most readily amenable to proper treatment.

We do not feel it wise to attempt to solve this entire problem by any one step or at any one time. We do not know how. We must feel our way cautiously so as to avoid waste and the creation of uncontrollable destructive forces, which once unleashed might wreck not only all we hoped to build but all that previously had served.

We are, therefore, recommending that those persons who are securing their subsistence from the government in direct relief, old age assistance, or WPA be given first consideration. We are suggesting that there be added to the amount allocated for food, shelter, clothing, and education of these people a small additional sum to be used to purchase medical care. This would not be great—not over



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fifty cents a month at the most. This sum could be spent by the state to pay for medical care secured by the patient from his own doctor, dentist or nurse. Such funds in order to be adequate would have to be collected from a large enough group to insure a sufficient reserve to meet emergencies and inequalities in distribution.

These are but a few highlights illustrating our present thinking for expansion of public health and medical care. These have been cited not because they are brilliantly outstanding but because they illustrate certain basic principles. In the first place the establishment of or the subsidizing of diagnostic centers is entirely an additional service. It does not in any way interfere with programs that are already successfully serving the people. It merely extends the field in two ways: to those who cannot purchase services of this nature at this time and to those for whom such services are not available even though they can purchase them.

The supplying of medical care through the practicing physician at the state expense for those groups who are without resources for any of their needs definitely limits the problem. By working with this group administrative technic will be learned. Then in due course of time the program can be enlarged to include that vast army of borderline cases who are able to meet the demands of food, shelter and clothing but cannot meet the catastrophic events of sickness. We are no more capable of revising the medical practice scheme than we are of making over the economic structures. We must take our problem piecemeal.

Such programs as these cannot be worked out or put into operation by government, by social agencies or by medical men working alone. The successful application of such ideas calls for careful thought and complete coöperation on the part of all agencies concerned. It is the function of the Department of Health to bring such agencies together so that forces may be mobilized to wage war against disease. No one should develop a mistaken idea that it is the function of any department of health or any branch of government to administer these services. It is our function to serve as intermediary agents between those who on the one hand command the forces of preventive and healing arts and those on the other hand who are in need of such services but are unable to secure them.

### MORTALITY DECREASING

Mortality reports for the first seven months of 1938 compiled by the Bureau of Records and Statistics show a decline in total deaths from 32,634 in 1937 to 29,636 this year. Infant mortality, too, is down from 2,673 in 1937 to 2,437 in 1938. Maternal deaths slightly exceed last year's figures when an all-time low rate for this cause was set. There were 188 maternal deaths last year compared to 200 this year. Births have increased from 52,649 in 1937 to this year's total of 55,341 for the seven-months' period.

Comparative mortality figures for the major communicable diseases in 1937 and 1938 are indicated in the table below:

Communicable Disease Mortality, 1937-1938				
Disease	July, 1938	July, 1937	7 Months, 1938	7 Months, 1937
Pneumonia	126	149	1,814	2,852
Tuberculosis	179	198	1,163	1,324
Typhoid Fever	1		14	10
Diphtheria	4	6	23	32
Whooping Cough	17	12	63	77
Scarlet Fever	5	2	67	112
Measles	6	3	95	7
Smallpox				1
Meningitis	1	4	13	30
Poliomyelitis	1	1	3	1
Syphilis	20	41	221	233
Gonorrhea		1	5	3



# PRELIMINARY REPORT OF A.P.H.A. SURVEY

A meeting of the Governor's Health Coördinating Committee has been set for October 14 in Lansing to hear the preliminary report on the survey of Michigan's health services conducted by the American Public Health Association. Dr. Carl Buck, field director, and his administrative associate, Dr. G. F. Amyot, will discuss the preliminary findings they have made during the survey which started here last June.

Members of the coördinating committee and the organizations represented include Dr. M. R. Kinde, W. K. Kellogg Foundation; Dr. B. W. Carey, Children's Fund of Michigan; Dr. P. C. Lowrie, State Dental Society; Dr. L. O. Geib, State Medical Society; Dr. John Sundwall, University of Michigan; and Dr. Don W. Gudakunst, State Health Commissioner. More than a score of representatives from various official and unofficial health agencies have also been invited to hear the preliminary report.

## 18TH ANNUAL PUBLIC HEALTH CONFERENCE

The 18th Annual Public Health Conference, sponsored by the Michigan Department of Health and the Michigan Public Health Association, is being held this year at Grand Rapids with headquarters at the Pantlind Hotel. Sessions will begin November 9 and continue for three days in the Grand Rapids Civic Auditorium.

Physicians, health officers, nurses, sanitarians, laboratorians and health educators have been invited to

attend the interesting and pertinent sessions which are being arranged by the program committee. The conference last year had an official registration of more than 1,200 persons.

The program will include discussions on the following topics: The Role of Sanitation in Disease Prevention, The Shiga Dysentery Outbreak, Rabies, Syphilis Control, Mental Hygiene, Pneumonia Control, Trends and Changes in Public Health Administration, Michigan's Cancer Control Program, The Nurse in the Program of Maternal and Child Health, and The Role of Government in the Provision of Medical Care.

## PERSONNEL

Dr. Richard Sears, epidemiologist with the Michigan Department of Health and recently acting director of the Muskegon County Health Department, has accepted a position as director of Health District No. 5, including Lake, Newaygo and Oceana counties. Dr. Sears succeeds Dr. Guy R. Post who has resigned. Headquarters of the district health department are at White Cloud.

Dr. William E. Bunney, director of the Biologic Products Division of the Michigan Department of Health for seven years, has resigned to accept a position as director of biologic products manufacturing for E. R. Squibb and Sons, New Brunswick, N. J.

Dr. George F. Forster, who has been engaged in research on pneumonia for the Michigan Department of Health during the past two years has resigned to become assistant director of the laboratories of the Illinois State Health Department at Springfield.

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## IN MEMORIAM

## Clinton C. Wright, M.D.

Dr. Clinton Carl Wright of Detroit, died on September 14, 1938. He was born in 1876, one of a family of physicians, in Edinboro, Pennsylvania. In 1900, he received his M.D. from the Cleveland Homeopathic Medical College, and in 1902 he located in Detroit where he was in general practice to the time of his death. Dr. Wright had been a member of the Grace Hospital Staff since 1902 after serving an internship at that hospital. He was also a member of the Wayne County Medical Society, Michigan State and American Medical Associations, the Detroit Athletic Club and the Lochmoor Golf and Country Club. Dr. Wright is survived by his wife, Mrs. Nina C. Wright; a daughter, Mrs. Frank Ford; a son, Charles H., and one grandchild.

## William Alexander Hackett, M.D.

Dr. J. H. Dempster, Editor  
Journal, Michigan State Medical Society  
Dear Doctor:

The notice of the passing of Dr. William Alexander Hackett, my life-long friend, was received not merely with regret but with the sense of a very deep personal bereavement. My wish is simply to relieve my own heart by expressing imperfectly what is shared by many others. If a man's worth may be measured by what is said of him after death, surely Detroit had no more worthy citizen

than Doctor Hackett. But good and true things were said of him while he lived. He was one among us who made no ostentatious showing of his citizenship. In his modest nature no love of display found a place, and he never sought after popularity which was alien to his nature. He was content to go through life much living unto others. He was true to his profession, true to the highest principles of that profession. To him the noble Hippocratic Oath was no mere grouping of words and phrases. He practised it as a doctor, obeyed it as a man. Doctor Hackett was a physician whose every patient was a friend. That is a legacy that few men are privileged to leave. Thrice blessed is he whose passing brings no unkind thoughts—so blessed was Dr. William Alexander Hackett.

Fraternally yours,

JAMES W. SCOTT, M.D.

Detroit, October 1, 1938.

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## ◆ General News and Announcements ◆

*Your 1939 Annual M.S.M.S. Convention* will be held in Grand Rapids, September 19, 20, 21, and 22—*A Four-Day Scientific Meeting*. Plans are now developing rapidly for another outstanding state convention.

\* \* \*

*The Ninetieth Annual Session* of the American Medical Association will be held at St. Louis, Missouri, May 15 to 19, 1939.

\* \* \*

*Don't forget your friends* (see page 1052) who advertise. They make possible the publication of *THE JOURNAL*. Please remember your friends when you need their services.

\* \* \*

*"Mental Hygiene"* was the subject of a talk given by Martin H. Hoffmann, M.D., of Eloise at the O.M.C.O.R.O. Medical Society meeting of October 21, at West Branch.

\* \* \*

*"A Medical Man's View of Socialized Medicine"* was the topic discussed by President Henry A. Luce, M.D., before the District Federation of Women's Clubs in St. Johns on October 19.

\* \* \*

*Joseph K. Heckert, M.D.*, Lansing, addressed the Barry County Medical Society on "Treatment of Sinusitis with Special Reference to Children" at the October 13 meeting held in Hastings.

\* \* \*

*The American Medical Golfing Association* will hold its Twenty-Fifth Annual Tournament at the North Hills County Club, St. Louis, on Monday, May 15, 1939.

\* \* \*

*Alvin E. Price, M.D.*, of Detroit gave an illustrated lecture on "Recent Advance in Serum Treatment of Pneumonia" at the meeting of the Hillsdale County Medical Society held October 27, in Hillsdale.

\* \* \*

*L. G. Christian, M.D.*, Lansing, addressed the Shiawassee County Medical Society in Owosso on October 20, on the subject "The Medical Gall Bladder." "The Surgical Gall Bladder" was discussed by Ralph Wadley, M.D., of Lansing.

\* \* \*

*"Serum Treatment of Pneumonia"* and "Treatment of the Surgical Complications of Pneumonia" were the respective subjects of Joseph F. Whinery, M.D., and Wm. R. Torgerson, M.D., of Grand Rapids, at the meeting of the Ionia-Montcalm County Medical Society held October 11, in Greenville.

\* \* \*

*Parker Heath, M.D.*, and *Roy D. McClure, M.D.*, of Detroit, were guest speakers on the program of the 1938 Convention of the Indiana State Medical Association held in Indianapolis. Doctor Heath's subject was "Management of Glaucoma." Doctor McClure spoke on "Diagnosis and Management of Cholecystitis."

\* \* \*

*The Washtenaw County Medical Society* invites all the internes in the county to its meetings and extends them the privileges of the society without any dues. In a recent letter addressed to the internes, the Society writes, "It is not too early for you to be aligning yourself with organized medicine as a future alert member of one of its societies."

*Printed copies* of the report of the Committee on Maternal Health of the Michigan State Medical Society entitled "Maternal Care in Michigan" are available free by sending a postal card to the Executive Office, 2020 Olds Tower, Lansing. This forty-four page report contains a wealth of information on maternal care in Michigan.

\* \* \*

*The North Central Branch* of the American Urological Association held its annual meeting in Peoria, Illinois, Sept. 29, to Oct. 2, 1938. Dr. John K. Ormond of Detroit presented a paper on "Necrosis of Part of Kidney with Temporary Urinary Fistula Following Section of Aberrant Vessel" and Dr. George C. Burr of Detroit presented a paper on "Utero-Vesical Fistula."

\* \* \*

The following officers were elected for the year 1938 and 1939 by the Section on Dermatology and Syphilology at the meeting of the Michigan State Medical Society, held in Detroit, Michigan during September, 1938. Chairman—Ruth Herrick, M.D., 26 Sheldon Avenue, S. E., Grand Rapids, Michigan; Secretary—Eugene A. Hand, M.D., 801 Second National Bank Building, Saginaw, Michigan.

\* \* \*

*At the annual meeting* and president's dinner of the Detroit Academy of Medicine on October 11, 1938, Dr. Edward D. Spalding was elected president, Dr. Douglas Donald, vice president, and Dr. Charles W. Lemmon, secretary-treasurer. Dr. Henry Carstens, the retiring president, became a member of the council of the Academy. As host for the evening, Dr. Carstens gave an address on Early Medical Days in Detroit.

\* \* \*

*Dr. A. S. Wheelock* of Goodrich, Michigan, an honorary member and past president of the Genesee County Medical Society, was honored by the people of Goodrich, who arranged a "Wheelock Day" is a testimonial of admiration and deep appreciation of Dr. Wheelock's service to their community. The date of the event was July 4. Dr. Wheelock was born December 7, 1861, at Bridgewater, Michigan. He attended grammar school and high school at Bridgewater and then entered the University of Michigan Medical School, where he was graduated in June, 1888.

\* \* \*

*The Association of Military Surgeons* wishes to complete its set of *THE JOURNAL* of the Michigan State Medical Society and is in need of the February 1937 issue. If any member can supply this number and is willing to contribute it to the Association of Military Surgeons, please write direct to H. L. Gilchrist, Major General, U. S. Army, Ret., National Secretary-Army Medical Museum, Washington, D. C., or write the Executive Office, 2020 Olds Tower, Lansing, as six other requests for this particular issue have been received.

\* \* \*

*The Committee of Seven* practicing physicians representing the American Medical Association (composed of Irvin Abell, M.D., Louisville, Ky., President of the A.M.A., Chairman; Henry A. Luce, M.D., Detroit; Frederic E. Sondern, M.D., New York; Walter E. Vest, M.D., Huntington, W. Va.; Walter F. Donaldson, M.D., Pittsburgh; Fred W. Rankin, M.D., Lexington, Ky.; and Edwin H. Cary, Dallas, Tex.) met with Miss Josephine Roche and the U. S. Interdepartmental Committee and its



Technical Committee on October 31 in Washington, D. C., to confer on methods of coördinating the health activities of the nation.

\* \* \*

The Tuscola County Medical Society, in cooperation with the Michigan Tuberculosis Association and the city of Vassar, is conducting a survey to determine exactly how much hidden tuberculosis exists in an average American community. All 4,000 inhabitants of Vassar will be given a tuberculin test, and those who react will be given an x-ray examination. The cost will be partially covered by voluntary contributions. If every community in the country were to conduct a similar survey, tuberculosis would soon become exceedingly rare.

\* \* \*

*Crippled and Afflicted Child Commitments*, for September, 1938:

Crippled Child: Total cases, 326, of which 109 went to University Hospital; 217 to miscellaneous hospitals. From Wayne County, of the above, 11 went to University Hospital, 51 to miscellaneous hospitals, total of 62.

Afflicted Child: Total cases, 1,973, of which 254 went to University Hospital; 1,719 went to miscellaneous hospitals. From Wayne County, of the above, 32 went to University Hospital and 358 went to miscellaneous hospitals; total of 390.

\* \* \*

The firm of E. R. Squibb and Sons of New York dedicated the new \$750,000 Institute for Medical Research, by which name it is known. It is located in New Brunswick, New Jersey. Dr. George A. Harrop is the director of the Institute. Addresses were delivered by Professor August Krogh, director of the department of animal physiology at the University of Copenhagen, and Dr. George R. Minot, professor of medicine at Harvard University. The meeting was also addressed by Dr. Abraham Flexner, of Princeton University; Dr. Russell Morse Wilder, professor of medicine in the Mayo Clinic; Mr. Carleton H. Palmer, president of E. R. Squibb and Sons; and Dr. John F. Anderson, vice president and director of the biological laboratories of E. R. Squibb and Sons.

\* \* \*

Talks given by the Michigan State Medical Society officers and the Executive Secretary include the following:

Speaker	City	Date	Organization	Subject
Henry Cook P. R. Urmston L. F. Foster F. T. Andrews Mr. Wm. J. Burns	St. Joseph	August 31	Berrien County Medical Society	"State Society Night"
Wm. E. Barstow Mr. Wm. J. Burns				
Mr. Wm. J. Burns	Howell	September 2	Livingston County Medical Society	"Plans for 1939"
Wm. E. Barstow L. F. Foster	Caro	September 8	Tuscola County Medical Society	"Michigan Health Conference"
Harold A. Miller Mr. Wm. J. Burns				
L. F. Foster	Caro	October 3	Rotary Club	"Socialized Medicine as it Affects Taxpayer"
L. F. Foster	Bay City	October 4	Rotary Club	"Crippled Children"
Mr. Wm. J. Burns	Portland	October 5	Lions Club	"Evils of Federalized Medicine"
Mr. Wm. J. Burns	Owosso	October 6	Rotary Club	"Evils of Federalized Medicine"
H. H. Cummings P. R. Urmston D. W. Gudakunst L. F. Foster	Howell	October 7	Livingston County Medical Society & County Supervisors	"County Health Units."
L. F. Foster				
Mr. Wm. J. Burns	Battle Creek	October 13	Kiwanis Club	"The Exceptional Child"
	Belding	October 25	Lions and Rotary Clubs	"What the Medical Society Means to the Community."

Doctor, remember your particular friends, the exhibitors at your Annual Convention, when you have need for equipment, appliances, medicinal supplies and service. Here are ten of the firms which helped make the 1938 Convention a great success:

Akron Truss Company, Detroit, Michigan  
A. S. Aloe Company, St. Louis, Missouri  
Arlington Chemical Company, Yonkers, New York  
The Bard-Parker Company, Inc., Danbury, Connecticut  
Bilhuber-Knoll Corporation, Jersey City, New Jersey  
Burroughs-Wellcome & Company, New York, New York  
S. H. Camp & Company, Jackson, Michigan  
Coca-Cola Company, Atlanta, Georgia  
Cottrell-Clarke, Inc., Detroit, Michigan  
R. B. Davis Company, Hoboken, New Jersey

\* \* \*

Mr. Lawrence C. Salter, formerly science editor of the *Detroit Free Press*, and now public relations assistant to Dr. Morris Fishbein, was tendered a farewell party on October 12, in Detroit, by a number of his friends. Among those present at the affair held in the Wayne County Medical Society headquarters, were Drs. Henry R. Carstens, Wm. A. Lange, S. E. Gould, Edward G. Duffy, J. Duane Miller, Matthew Balcerski, L. J. Bailey, James Lightbody, A. S. Brunk, C. E. Umphrey, Wm. A. Hyland, L. Fernald Foster, P. R. Urmston, L. J. Hirschman, Henry A. Luce, W. B. Cooksey, C. K. Valade, T. K. Gruber, David Sugar; also Messrs. Andy Burkhardt and Edgar A. Guest, Jr., of the *Free Press*, A. M. Smith of the *Detroit News*, Wm. J. Burns, J. A. Bechtel, and Harry R. Lipson. A travelling case was presented to Mr. Salter by his medical friends.

\* \* \*

The Third Congress of the Pan-Pacific Surgical Association will be held in Honolulu, September 15 to 28, 1939. All surgeons of the Michigan State Medical Society are invited to attend for the purpose of meeting fellow practitioners from Australia, New Zealand, China, Japan, Java, Canada and the United States, and to promote a better understanding and interchange of ideas among surgeons of these countries. There will be sections in fractures and orthopedics, general surgery, gynecology, neurosurgery, ophthalmology, otolaryngology, roentgenology, plastic surgery, thoracic surgery and neurology. Further information may be obtained by writing to George W. Swift, M.D., 902 Boren Avenue, Seattle, past president of the Association; Frederick L. Reichert, M.D., Stanford University Hospital, San Francisco; or Forrest J. Pinkerton, M.D., secretary-treasurer of the Association, Young Building, Honolulu, Hawaii.

Wm. M. Donald, M.D., of 938 David Whitney Building, Detroit, is compiling a short history of the Northern Tri-State Medical Association, now in its seventieth year of activity.

The founders and early officers of this hustling and aggressive organization seem to have been careless in preserving the official documents incident to the creation and development of the society, and, hence, the historian's task is a heavy one.

Any information relative to the Society during the period between 1870 and 1885 will be highly appreciated by Dr. Donald.

\* \* \*

A joint meeting of the Michigan Tuberculosis Association, Michigan Trudeau Society, and the Michigan Sanatorium Association was held on October 15th. The following are papers presented at this meeting, which was held in Muskegon: Some Cardiac Conditions, by Dr. William M. La Fevre of Muskegon; A Study of Basilar Lesions in Pulmonary Tuberculosis, by Dr. Lauren F. Busby, Maybury Sanatorium, Northville; Studies on the Sputum of Tuberculosis Patients Treated by Extra-Pleural Thoracoplasty, Dr. William M. Tuttle, Detroit, Dr. C. J. Stringer, Ingham County Sanatorium, Lansing, and Dr. E. J. O'Brien, Detroit; The Fate of the Contralateral Lung in Pulmonary Tuberculosis, by Dr. A. D. Calomeni of the Saginaw County Sanatorium; The Sedimentation Rate in Tuberculosis, by Drs. Donald S. Smith of Pontiac and John B. Barnwell of the University Hospital, Ann Arbor; The Anemia of Pulmonary Tuberculosis, by Dr. Maurice Braverman, Maybury Sanatorium, Northville; Hawaii, by Dr. Bruce H. Douglas; The General Practitioner in Tuberculosis by Dr. Robinson Bosworth, President, Illinois Tuberculosis Association; and a Report on Plans for the Upper Peninsula, by Dr. A. W. Newitt, of the State Department of Health.

\* \* \*

### THIRTEENTH ANNUAL CLINIC OF THE HIGHLAND PARK PHYSICIANS' CLUB

Highland Park General Hospital, Highland Park,  
Detroit, Michigan  
November 30, 1938

Morning Session—9:00-12:30

#### Clinical Pathological Conference

Donald C. Beaver, M.D., F.A.S.C.P., Pathologist,  
Women's Hospital, Detroit  
"Placental Blood Bank"

James R. Goodall, M.D., F.C.O.G., Professor of  
Clinical Gynecology and Obstetrics, McGill Uni-  
versity, Montreal, Canada.

#### "Clinical and Radiological Aspects of Diseases of the Paranasal Sinuses"

E. H. Shannon, M.D., F.B.A.R., Director, Depart-  
ment of Radiology, St. Michael's  
Hospital, Toronto, Canada.

J. A. Sullivan, M.B., Demonstrator in Oto-  
laryngology, University of Toronto, Toronto,  
Canada.

#### "The Treatment of Anemia"

Russell L. Haden, M.D., F.A.C.P., Chief of Division  
of Medicine, Cleveland Clinic, Cleveland, Ohio.

Luncheon—12:30-2:00

#### Address of Welcome

Blaine T. Colman, Mayor of Highland Park.  
Complimentary Luncheon by the Highland Park  
General Hospital.

Afternoon Session—2:00-5:00

#### "Carcinoma of the Stomach"

Frederick Christopher, M.D., F.A.C.S., Professor of  
Surgery, Northwestern University, Chicago,  
Illinois.

#### "Clinical Aspects of Water Turnover"

Martin Fischer, M.D., F.A.P.S., Joseph Eichberg,

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James R. Goodall, M.D., F.C.O.G., Professor of Clinical Gynecology and Obstetrics, McGill University, Montreal

Banquet—7:00 P. M.

Annual Banquet, Detroit Athletic Club (Stag)  
Toastmaster: Henry A. Luce, M.D., President, Michigan State Medical Society

Speaker: Malcolm W. Bingay, Editorial Director, *Detroit Free Press*, Honorary Member, Wayne County Medical Society.

\* \* \*

Graduate Conferences for physicians sponsored by the Wayne County Medical Society, the Detroit Department of Health and Wayne University College of Medicine. Four conferences will be held during the month of November, all at Herman Kiefer Hospital and starting promptly at 10:00 a. m.

Wednesday, November 2—"Gestation Deficiencies" by Fred Adair, M.D., Chicago

Wednesday, November 9—"Psychiatric Aspects of Medical Practice" by Wm. S. Sadler, M.D., Chicago

Wednesday, November 16—"What the Physician in General Practice Should Know About Tuberculosis" by Henry D. Chadwick, M.D., Waltham, Mass.

Wednesday, November 23—"Fever of Unknown Origin in Children" by Rustin McIntosh, M.D., New York City

Every member of the Michigan State Medical Society is cordially invited to attend.

\* \* \*

Dr. Henry A. Luce, president of the Michigan State Medical Society, is chairman of a Committee to Survey Health Needs of the State. The committee consists of Dr. Luce, chairman, Drs. E. J. O'Brien, Henry F. Vaughan, Commissioner of Health of Detroit, Dr. Cyrus Sturgis, Professor of Medicine, University of Michigan, and Dr. Paul de Kruif, noted for his ability as an author and popularizer of medicine for the layman, Mr. Wm. J. Scripts of Detroit, and Mr. Louis J. Nims of Lansing.

It will be remembered that a committee was authorized by the recent special meeting of the House of Delegates of the A.M.A. to confer with federal officials on the National Health Program. Dr. Luce has been appointed by Dr. H. H. Shoulders, speaker of the House of Delegates of the A.M.A., on the Committee, other members of which are Dr. Irving Abell, president of the A.M.A. who is chairman, and Drs. Walter F. Donaldson of Pittsburgh, Walter E. Vest of Huntington, W. Virginia, Fred W. Rankin of Lexington, Ky., Frederick D. Sondern of New York, E. H. Cary, past president of the A.M.A., of Dallas, Texas, Rock Sleyster of Wauwatosa, Wisconsin, and Dr. Olin West, secretary of the A.M.A.

## CONVENTION ECHOES

The registration at the 1938 Annual Meeting of the Michigan State Medical Society in Detroit was as follows:

Physician-members ..... 1,594  
Guests (mostly M.D.'s from other states) ..... 302

Exhibitors ..... 181

GRAND TOTAL ..... 2,077

The out-of-state guest speakers on the General Assembly program at the Detroit meeting were tremendously impressed by the generous size of the audiences which were on hand from 9:30 a.m. until 5:00 p.m. daily to hear the postgraduate

instruction brought to them at the M.S.M.S. convention. A number of essayists requested an invitation to return to Michigan for some future annual meeting.

*Dr. Wm. S. Sadler* of Chicago was guest speaker at the Secretaries' Conference, through the courtesy of the Kellogg Foundation. Present at the Secretaries' Conference were *Dr. Stuart Pritchard*, General Director of the Kellogg Foundation, Battle Creek, and *Dr. M. R. Kinde*, its Director of Medical Service.

*Seventy-four physicians* attended the Secretaries' Conference of September 20 in Detroit on the occasion of the M.S.M.S. Convention. Among the county medical society secretaries present were: *Drs. M. B. Beckett, T. H. Cobb, A. L. Ziliak, F. S. Leeder, Wilfrid Haughey, T. Y. Ho, G. W. Benson, W. H. Huron, T. Wilensky, C. W. Colwell, C. E. Lemmen, R. L. Waggoner, E. G. McGavran, E. W. Blanchard, R. J. Himmelberger, J. J. McCann, H. W. Porter, L. W. Gerstner, J. M. Whalen, E. T. Morden, D. C. Stephens, C. D. Hart, R. F. Salot, Florence Ames, O. O. Beck, C. G. Clippert, D. C. Bloemendaal, J. H. Burley, J. W. Rice, R. R. Howlett, Wm. M. Brace, B. I. Johnstone, B. A. Holm.*

Presidents of county medical societies present were *Drs. G. F. Fisher, Mark Osterlin, J. N. Scher.*

Officers, councilors and committeemen of the State Society present were *Drs. H. A. Luce, B. R. Corbus, J. H. Dempster, L. Fernald Foster, P. R. Urmston, P. A. Riley, M. H. Hoffmann, A. S. Brunk, I. W. Greene, V. M. Moore, J. E. McIntyre, F. T. Andrews, W. E. Barstow, H. H. Cummings, R. H. Holmes, Henry Cook, L. G. Christian, T. K. Gruber, R. B. Harkness, H. A. Miller, A. V. Wenger, G. M. Byington, J. A. Hookey, G. C. Stucky, Leon Bogart, G. D. Bos, P. E. Sutton, L. D. MacRae, L. R. Keagle, M. A. Hoffs, H. C. Hill, Wm. R. Torgerson, Hugh Robbins, D. K. Barstow, A. Bernhard.*

Among the other guests were Health Commissioner *Don W. Gudakunst*, *Drs. Stuart Pritchard, M. R. Kinde, Mr. L. C. Salter, Mr. W. L. Williams, Miss Mabel Skinner, Miss M. O. Smith, Miss Rosabelle Snohr, Miss V. M. Leahy, Mr. H. R. Lipson, Mr. Frank Lark.*

*President Henry A. Luce* outlined the 1938-39 program of the Michigan State Medical Society to the committee chairmen at the Annual Organizational Luncheon held in Detroit on September 20. Among those present were *Doctors Luce, Henry Cook, Martin H. Hoffmann, James D. Bruce, F. T. Andrews, T. K. Gruber, L. G. Christian, A. M. Campbell, W. E. Barstow, P. R. Urmston, Grover C. Penberthy, H. H. Cummings, L. O. Geib, L. Fernald Foster, Wm. A. Hyland, Henry R. Carstens, H. W. Porter, Clarence D. Hart, Charles E. Dutchess, W. H. Huron, Ralph H. Pino, Paul A. Klebba, L. C. Harvie, and Harold A. Miller.*

*Three hundred eleven (311) inches* of copy were published in the newspapers of Detroit relative to the 1938 convention of the Michigan State Medical Society. In addition over 600 inches of copy were published in the newspapers outside of Detroit.

*Dr. J. Duane Miller* of Grand Rapids headed a very efficient Press Relations Committee, composed of *Drs. Fred G. Buesser and David I. Sugar*, of Detroit, and *Dr. Miller*, to which credit is due for the splendid press notices on the convention activities.

Among the newspaper representatives who covered the meeting were *Lawrence C. Salter, Detroit*



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*Free Press; A. M. Smith, Detroit News, and Miss Dorothy Williams of the Detroit Times.*

Dr. Martin H. Hoffmann of Eloise added to his laurels for versatility by demonstrating his abilities as a song leader at the M.S.M.S. Convention. The quality of his basso profundo was thoroughly enjoyed at the Exhibitors Gridiron of September 21.

President Henry A. Luce was toastmaster on this occasion; Dr. Frank A. Kelly of Detroit gave the scientific address of the evening.

One of the high points of the evening was the excellent singing of Mr. Jack Moldowan, who entertained through the courtesy of Cottrell-Clarke, Inc., of Detroit, an exhibitor.

Mr. Frank M. Rhatigan, secretary of the Medical Exhibitors Association, Danbury, Connecticut, attended the Michigan State Medical Society convention as official representative of his association. Mr. Rhatigan expressed great appreciation for the courtesies extended by the M.S.M.S. members to the exhibitors.

The lucky winners of DeLuxe Traveling Kits, presented by the Mennen Company in booth number 48, were Drs. Albert Bernstein, R. W. Cavell, H. W. Hewitt, Scipio Murphy and Wm. J. Stapleton, Jr., all of Detroit, and Joseph L. Baer, M.D., of Chicago, Ill.

Coca-Cola dispensed 2,329 bottles of their product to thirsty physicians and guests during the three days of the Convention.

The Radio Committee of the Michigan State Medical Society sponsored the following talks during the Convention of the Society in Detroit, September 19-20-21-22:

### September 19

Clark D. Brooks, M.D., WJR—What the Michigan State Medical Society is Accomplishing.  
Gene Osius, M.D., WEXL—Surgery.  
O. A. Brines, M.D., CKLW—Cancer.  
Louis A. Schwartz, M.D., CKLW—Discipline of the Child in the Light of the Intra-Family Relationship.  
J. E. G. Waddington, M.D., WEXL—Is Medical Care Inadequate? If so, Why?

### September 20

Morris Fishbein, M.D., WWJ—The Discussion of Modern Social Trends in Medical Practice.  
B. R. Corbus, M.D., CKLW—New Plans in Medicine.  
A. D. Ruedemann, M.D., WJR—Conservation of Vision.  
Roger S. Siddall, M.D., WEXL—Maternal Health.  
Paul McQuiggan, M.D., CKLW—County Aid in Medical Care.  
Harry S. Berman, M.D., WEXL—The Common Cold.

### September 21

Ralph H. Pino, M.D., WJR—Distribution of Medical Care to the American People.  
F. T. Andrews, M.D., WEXL—Development in Modern Surgery.  
Martin H. Hoffmann, M.D., CKLW—Patients Also Treat Doctors.  
C. E. Umphrey, M.D., CKLW—The Place of Organized Medicine in Wayne County.  
W. L. Quennell, M.D., WEXL—The Role of the American Hospital.

### September 22

Henry Cook, M.D., CKLW—The Progressive Attitude of American Medicine.  
Henry R. Carstens, M.D., WJR—The Dissemination of Medical Knowledge.  
Wm. J. Stapleton, Jr., M.D., WEXL—Ideals in Medicine.  
Harry Pierce, M.D., WEXL—What is the Meaning of Prenatal Care.  
M. H. Erickson, M.D., CKLW—Mental Hygiene.

The Radio Committee, through its chairman, Fred H. Cole, M.D., wishes to take this opportunity of thanking the above speakers for their splendid cooperation.

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*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**YOU CAN SLEEP WELL. THE A B C'S OF RESTFUL SLEEP FOR THE AVERAGE PERSON.** By Edmund Jacobson, M.D. New York, Whittlesey House, London: McGraw-Hill Book Company, Inc., 1938, \$2.00.

**CHALLENGE TO SEX CENSORS.** By Theodore Schroeder. Privately printed to promote the aims of the Free Speech League, New York City, 1938.

**SYPHILIS, GONORRHEA, AND THE PUBLIC HEALTH.** By Nels A. Nelson, B.S., M.D., F.A.P.H.A., Director, Division of Genitoinfectious Diseases, The Massachusetts Department of Public Health, and Gladys L. Crain, R.N., Epidemiologist, Division of Genitoinfectious Diseases, The Massachusetts Department of Public Health. New York: The MacMillan Co., 1938.

**ANUS, RECTUM, SIGMOID, COLON: DIAGNOSIS AND TREATMENT.** By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S. Assistant Professor of Proctology, Temple University, School of Medicine. Introduction by W. Wayne Babcock, A.M., M.D., L.L.D., F.A.C.S., Professor of Surgery, Temple University School of Medicine. Foreword by J. P. Lockhart-Mummery, M.A., M.B., B.C. (Cantab), F.R.C.S. (Eng.). Emeritus Surgeon, St. Mark's Hospital, London, England. 487 illustrations in the text mostly original by William Brown McNett. Philadelphia, Montreal, London: J. B. Lippincott Co.

**HUMAN PATHOLOGY, A TEXTBOOK.** By Howard T. Karsner, M.D., Professor of Pathology, Western Reserve University, Cleveland, Ohio. With an introduction by Simon Flexner, M.D. 18 illustrations in color and 443 in black and white. Fifth edition, revised. Philadelphia & London: J. B. Lippincott Co.

**OUTLINE OF ROENTGEN DIAGNOSIS.** An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. By Leo G. Rigler, B.S., M.B., M.D. Professor of Radiology, University of Minnesota, Minneapolis, Minnesota. Atlas Edition, 254 illustrations shown in 227 figures, presented in drawings and reproductions of roentgenograms. Figures 6 to 51 and 55 to 72 are drawings in an original technic by Jean J. Hirsch, Philadelphia, London, Montreal, New York: J. B. Lippincott Co.

**THE COMPLEAT PEDIATRICIAN.** By Wilburt C. Davison, M.A., D.Sc., M.D. Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital. Acting Pediatrician in charge, The Johns Hopkins Hospital. Fellow American Academy of Pediatrics and American College of Physicians. Member White House Conference, American Pediatric Society, and American Board of Pediatrics. Second completely rewritten edition. Durham, N. C.; Seeman Printery for Duke University Press, 1938.

The title is adapted from the "The Compleat Angler" by Isaak Walton. This work deals with practical, diagnostic, therapeutic and preventive pediatrics and is especially recommended as a quick reference for medical students, internes, general practitioners and pediatricians. The author makes an up-to-date digest of the vast amount of pediatric literature accumulated during the past four years in the various journals. Indications for the use of the relatively recent "panacea," sulphanilamide, are included.

Chapters on growth and development, laboratory procedures, and infant feeding and child nutrition are noteworthy, particularly the former, in as much as the average physician overlooks the fundamentals of normal growth and development of the child's mental as well as physical processes. Thorough understanding of these is essential for a true appraisal of the growing child. Several pages are devoted to drugs and prescriptions commonly used in pediatric practice. In all, a large field has been ably handled in a clever and concise manner in this small book which should appeal to the progressive physician.

**PEDIATRIC SURGERY.** By Edward C. Brenner, A.B., M.D., F.A.C.S. Director of Surgery, Riker's Island Hospital; Director of surgery, Detention Hospital; Attending Surgeon, Midtown Hospital, Associate Professor Clinical Surgery, New York Post-graduate Medical School, Columbia University; Associate Attending Surgeon and Chief of Clinic, Post-graduate Hospital; Consulting Surgeon, Hunt's Point Hospital; Fellow of American Medical Association, American College of Surgeons. New York Academy of Medicine; former Surgeon, Squadron A. Illustrated with 293 engravings. Philadelphia: Lea and Febiger, 1938.

Pediatric surgery is now an accepted branch of general surgery and it seems timely to have a book correlating the affections peculiar to childhood and the treatment thereof. We recognize differences in certain diseases in the child and in the adult and many conditions seen in childhood are uncommon or are not seen at all in adult surgery, especially the congenital deformities. However, it is not so much the differences in the manifestations of the disease processes in the two as it is the judicious handling of the more delicate situation in the infant or child that demands most attention. Particularly, must the pediatric surgeon bear in mind that his patient's body is no place for heroic surgery.

In this book, the author has responded to a request by students for a text on surgery of infants and children. Most texts on general surgery already include this more limited field but do not cover it so completely, nor so well.

Fractures, dislocations and orthopedic conditions have rightly been omitted to allow for more discussion of the other surgical subjects. Many operations are described in detail and the essentials of pre- and post-operative treatment are emphasized.

Six specialists have contributed noteworthy chapters on anesthesia, blood transfusions, congenital cleft lip and palate, thoracic surgery, urology, and neurologic surgery, all of which add considerable to the value of the book.

**THE FIGHT FOR LIFE.** By Paul DeKruif, Book-of-the-Month Club selection, published by Harcourt-Brace and Company, Inc., 383 Madison Avenue, New York.

A book written in extremely interesting fashion. One may not always agree with the writer in his conclusions. It does challenge the reader, if he is a medical man, to give interest to and do his best.

H. C.

**ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY** of the American Medical Association for 1937, with the Comments that Have Appeared in The Journal. Cloth. Price, \$1.00. pp. 201. Chicago: American Medical Association.

This book is a great deal more than a mere record of the negative actions of the Council on Pharmacy and Chemistry. It gives in full the reasons for the Council's rejection of various preparations, but it also records results of the Council's investigations of new medicinal agents not yet out of the experimental stage, and frequently contains reports on general questions concerned with the advance of rational drug therapy. All three categories of reports are represented in the present volume.

This issue of the Reports is remarkable for the series of valuable status and preliminary reports published by the Council in the past year. These include the reports on Avertin with Amylene Hydrate (now accepted for New and Nonofficial Remedies), Benzedrine Sulfate (the active constituent of the notorious "pep" pills but a promising drug when its limitations are recognized), Catgut Sutures (a survey of the sterility of the market supply), Evipal Soluble (a comprehensive review of the evidence for the usefulness and limitations of the drug), Histidine Hydrochloride (a study of the usefulness of the drug in peptic ulcer, to be considered in connection with the report rejecting



Larostidin, a proprietary brand, for unwarranted and exaggerated claims), Mandelic Acid (an authoritative statement of the limitations of this drug which the Council has now accepted), and Vincethene (a careful study of the evidence for the drug, which the Council has accepted for one year as an anesthetic to be used in short procedures).

Other notable reports of outright rejection of products are those on Causalin (Causyth), an unsafe and dangerous preparation proposed for use in arthritis; Glutamic Acid Hydrochloride-Calco, proposed as a conveyor of hydrochloric acid, with unsubstantiated claims of clinical effectiveness; Larodon "Roche," proposed as a substitute for other well

established analgesic and antipyretic drugs and marketed with exaggerated and unwarranted claims.

Two reports on Sulfanilamide appear, a nomenclature and status report together with reprints of *The Journal* editorials giving the warnings which, if obeyed, would have avoided the series of deaths which resulted from the marketing of the ill-fated Elixir of Sulfanilamide-Massengill.

At the end of this volume appears a eulogy of George Henry Simmons, whose death deprived the Council on Pharmacy and Chemistry of its founder and American medicine of a worthy and faithful servant.

## AMONG OUR CONTRIBUTORS

**Dr. Samuel S. Altshuler** was graduated from the University of Michigan Medical School in 1925. He specialized in Internal Medicine. He was formerly instructor in the Department of Internal Medicine, University of Michigan College of Medicine. He is Assistant Physician to the Out-Patient Department of Harper Hospital; Attending Physician at William J. Seymour Hospital, Eloise, Michigan; Clinical Instructor in Internal Medicine, Wayne University College of Medicine. He is a Fellow of the American College of Physicians.

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(1) Derbyshire, A. J., and Davis, H.: "The Action Potentials of the Auditory Nerve," *Amer. Jour. Physiol.*; vol. 113, pp. 476-504, 1935.

(2) Derbyshire, A. J., Rempel, B., Forbes, A., and Lambert, E. F.: "The Effects of Anesthetics on Action Potentials in the Cerebral Cortex of the Cat," *Amer. Jour. Physiol.*, Vol. 116, pp. 577-596, 1936.

\* \* \*

**Dr. Haven Emerson** was graduated from the Columbia Medical School in 1899. He was Assistant in Medicine at Columbia from 1906 to 1910. From 1915 to 1917, he was Commissioner of Health and President of the Board of Health of New York

City. He served a year as Professor of Hygiene and Preventive Medicine at Cornell, and later as Professor of Public Health Administration and Director of the DeLamar Institute of Public Health at the College of Physicians and Surgeons of Columbia University. In 1929, he went to Athens, Greece, for the Survey of Health and Sanitation for the League of Nations and in 1931, he was a member of the National Advisory Health Council. Dr. Emerson was also a member of the Committee of Expert Statisticians of the League of Nations.

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### THE MANAGEMENT OF VARIOUS TYPES OF COLITIS\*

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J. A. BARGEN

The term "colitis," strictly speaking, is the designation for inflammation of the colon. It means no more and no less. This emphatic statement is made because there seems to have been a growing tendency to use the term "colitis" interchangeably with "diarrhea" and "dysentery" and to apply it to all manner of vague abdominal disturbances. Abdominal discomfort associated with intestinal spasm has also been glibly called "colitis." This only makes for confusion in the profession and for false fear among laymen.

While, in general, "dysentery" is the name applied to a form of infectious enteritis, its differentiation from diarrhea is more apparent than real. "Dysentery" originates from two Greek words meaning "ill" and "intestine." "Diarrhea" refers to a persistent looseness of the stools. Dysenteric stools may alternate with diarrheal stools in a single case and both may be present without the presence of "colitis." The last-named term is not tenable unless inflammation of the colon is demonstrable. Furthermore, in the common forms of colitis of the North Temperate Zone, the various inflammatory lesions of the colon are usually readily distinguishable one from the other. To this end a well regulated set of objective investigations are indicated, including, in order, careful physical examination and rectal (digital) examination, study of the stools and rectal discharges, proctoscopic observation and roentgenologic studies.

\*Read before the meeting of the Michigan State Medical Society, Detroit, Michigan, September 20, 1938.

#### The Common Colitides

The common forms of colitis are: (1) amebic, (2) tuberculous, (3) thrombo-ulcerative (streptococcic), (4) ulcerative colitis of unknown etiology, and (5) so-called "mucous colitis." The last-named, of course, by the very nature of the definition, should find no place in this classification. Because of its common inclusion in discussions on colitis, however, it is mentioned here in order to clarify our viewpoint regarding its nature. The term "irritable colon" describes the condition commonly designated as "mucous colitis" much more adequately. It at once suggests that the cause of the difficulty should be searched for at points distant from the intestine. "Mucous colitis" is therefore part of a systemic disturbance of a functional nature.

#### "Mucous Colitis"

When it has been definitely established



that a diarrhea is the result of a disturbance of this type, treatment may often be very difficult. The most important factor in a well-regulated program of management in these cases has to do with convincing the patient that his diarrhea is of a functional nature. Since it may not be easy to convince him that his nervous irritability is causing the diarrhea, a carefully planned and well regulated set of objective tests become an important part of the treatment, and when the nature of the systemic disturbance has once been established, treatment of the diarrhea itself becomes a secondary problem. The patient may have to avoid those things which upset his nervous system. He may have to avoid certain foods which are followed by intestinal disturbances. Of course, when the diarrhea is the result of such things as food poisoning or trichinosis, specific treatment is in order; and when it is caused by exophthalmic goiter, adequate treatment of the hyperthyroid state will result in control of the diarrhea. In my experience diarrhea occurs only in the late stages of uremia, when treatment of the uremic state may not be possible. In any event, however, treatment in such cases should be directed to the renal condition rather than to the intestine.

The same things may be said about the control of functional gastro-intestinal disturbances. So-called irritable or unstable colon is a condition in which the intestine plays only a small rôle in the production of the diarrhea, the colon being only one of the organs whose function is deranged. While relief of the diarrhea may be advisable, the major part of the treatment should consist in control of the general bodily disturbance. No fixed regimen is possible for all of these patients. The program must therefore be individual and it will entail patience on the part of the patient and physician alike.

#### **Amebic Colitis (Amebiasis; Amebic Dysentery)**

Chemotherapy plays a very important part in the treatment of this parasitic disease. The purpose of treatment in these cases is twofold: (1) to eradicate the parasite in the walls of the intestine and in other distant foci, and (2) to promote healing of the lesions they have produced. Emetine hydrochloride, administered hypo-

dermically, and treparsol, given by mouth, have been found most useful in the treatment of amebiasis. It has been our custom at the clinic to inject 0.043 gm. (2/3 grain) of emetine hydrochloride about every twelve hours in the average case until 4 grains (0.24 gm.) are delivered. In some of the more severe cases 6 grains (0.4 gm.) have been given. After a rest of a week this same course is repeated, providing no untoward effects have occurred. Beginning on the day that the emetine hydrochloride is given, 0.25 gm. of treparsol is given by mouth three times a day. It is well to have the patient chew a tablet before each meal until twelve tablets are taken. This course is repeated in a week and with the same precautions.

One must never lose sight of the fact that these drugs are toxic and that the margin of safety between toxicity and therapeutic effect is not great. In some instances it is well to combine these drugs with vioform or some other of the complex iodine drugs. If this seems indicated, vioform may be given between the courses of treparsol and after the second one, again in tablet form three times a day. Sometimes, too, a third course of treparsol may be required. Following a so-called adequate course of treatment, stools should be examined on at least three consecutive days.

Drugs like bismuth are commonly used for symptomatic relief. In case this seems wise, large doses (3 or 4 drams) three or four times a day should be given. The diet should be generous but bland and it should be graded more or less bland according to the severity of the disease. Rest in bed is only occasionally necessary during this treatment.

#### **Tuberculous Colitis**

The common type of intestinal tuberculosis secondary to disease of the lungs resembles amebiasis in its involvement of the intestine. No specific treatment for it is as yet available; hence, the differential diagnosis of these two conditions is of utmost importance. Rest in bed and heliotherapy constitute the keynote of treatment. The object must be to take as much of the burden off the inflamed and handicapped bowel as is possible. The diet should be somewhat similar to that used in the treatment of thrombo-ulcerative colitis, which

will be discussed later. It should be smooth, relatively low in residue and high in calories. Attempts at specific treatment have included the injection of oxygen into the peritoneal cavity, roentgen therapy over the abdomen, and even opening and closing the abdomen surgically.

Among the drugs which have found favor in the treatment of tuberculous colitis are calcium, arsenic and mercury. Many other drugs have been employed, but the important thing to remember is that intestinal rest is of paramount importance. The prognosis in tuberculous enterocolitis is unfavorable and the condition is usually terminal. When the lesion is local and involves but a short segment of intestine, or in the case of the hyperplastic tuberculosis, surgical resection has yielded satisfactory results in many cases.

#### Thrombo-Ulcerative (Streptococcic) Colitis

This disease afflicts human beings in a remarkably dissimilar manner. It may begin insidiously and remain mild throughout its course; on the other hand it may begin insidiously, remain mild for a time, and then suddenly become very severe, or it may begin as a severe fulminating illness. Consequently, the treatment varies considerably for different groups of patients and many different therapeutic measures are brought into play.

*Rest.*—As with all serious and destructive diseases, rest of the body generally, and of the diseased part specifically, is invaluable. In this case it is not always rest in bed that is necessary, although this is of great importance in the severe and fulminating types of the disease, but restful recreation with a minimum of trauma to the diseased intestine, even in less actively infected bowels, that is of paramount importance. This at once implies that intestinal irrigation with medicated solutions is not a desired form of treatment. Rather, what is wanted is physical and mental rest.

*Diet.*—The diet should be generous but should aim to afford a minimum of intestinal irritation. In mild to moderately active cases the diet should be rich in calories—proteins, carbohydrates, vitamins, minerals—and yet relatively low in residue. Intestinal peristalsis is aggravated in all these cases. Protein foods leave relatively little residue

and are digested high in the intestinal tract; hence the average individual should receive 100 gm. or more of protein daily. The other articles of diet should be graded up or down as the individual needs require. True enough, many cases are encountered in which parenteral fluids and feeding are required, it being of great importance to keep up the fluid balance of each individual. For this purpose glucose solution given intravenously and saline solution given subcutaneously have proved particularly valuable.

*Serum.*—The serum prepared by immunization of horses with the offending streptococcus has in most cases proved of great value. Such serum is usually best administered intramuscularly, although in severe and fulminating cases its intravenous administration has proved of inestimable worth.

*Vaccine.*—In the less severe, more chronic and subsiding cases the vaccine prepared from the streptococcus of colitis has been particularly helpful.

*Blood Transfusion.*—Most patients with thrombo-ulcerative colitis have some degree of anemia, and this may become profound. Varying degrees of sepsis and associated toxemia are encountered. Both of these conditions provide ample cause for blood transfusion. The manner of giving blood to these patients is important. Frequent small transfusions (from 100 to 250 c.c. at a time) given as frequently as every two to four days have been particularly efficacious.

*Oxygen.*—Oxygen depletion and oxygen want is apparent in cases of the more severely ill of these patients. Hence supplying oxygen to the body generally should be worth while—not instilling it into the rectum, as some have done, for I believe this causes too much colonic irritation, but administering it by inhalation. We at the clinic have been able to provide oxygen in a most satisfactory way by means of the mask recently devised by Boothby, Lovelace and Bulbulian.

*Intestinal Antiseptics.*—Medications too numerous to mention have been advocated for the treatment of this disease. Most of them are to be mentioned only because of their relative lack of merit. Particularly is this true of most of the so-called intestinal antiseptics; in my experience this in-



cludes not only the older mercurochrome, gentian violet, argyrol, acriflavine and many others, but the more recent ones such as azochloramide as well. Except in those cases in which there is much anal irritation and in which the disease is limited to the distal segments of the large intestine, I believe the instillation of medicated solutions into the rectum is not indicated. In some cases of involvement of the distal segments such mixtures as aluminum hydroxide and kaolin may have some value. Powders given by mouth in large amounts, such as bismuth subnitrate, tribasic calcium phosphate and collosol kaolin, by their absorption of water and consequent reduction of the number of bowel motions, seem to have definite value.

*Opium or Codein.*—Any substance tending temporarily to splint the bowel serves a purpose, and to this end minimal amounts of opium or codein are desirable. They should be used, however, only for short periods of time.

*Iodine.*—Just what the rôle of iodine is in the control of a diarrhea remains an unsolved problem, but that it has a favorable effect in some of these cases cannot be denied. Tincture of iodine, administered in water in doses of 10 to 15 drops three times a day, seems to help a number of the patients. I once estimated that about 15 per cent of our patients were thus benefited.

*Calcium and Parathyroid Extract.*—Some patients with the milder forms of thrombo-ulcerative colitis seem to have obtained benefit from the use of calcium and parathyroid extract, the number of such patients, however, being very small. I have never been quite sure that the few who were benefited were not aided by the psychic effect of administration of the drugs plus rest and the other elements of the program provided.

*Histidine Hydrochloride.*—An occasional patient with thrombo-ulcerative colitis has been benefited by the administration of 5 c.c. of a 4 per cent solution of histidine hydrochloride. Again, patients so benefited had the milder types of the disease. This drug has been given daily for several weeks.

*Iron.*—Iron is another valuable medica-

tion in this condition, but the preparation chosen is of greatest importance as so many iron products will increase diarrhea.

*Pectin.*—Pectin and apple powder seem to have helped in a few cases, but in my experience only very temporarily.

*Arsenic.*—Arsenic, in the form of carbar-sone or some similar preparation, should be used only for its tonic effect and then only when the active stage of the disease, with marked bleeding, has subsided. In the main, arsenic may be considered as an unsafe drug in the treatment of this disease.

*Neoprontosil.*—The sulfanilamide group of drugs has recently come into prominence in the treatment of many streptococcal infections. Theoretically, therefore, these drugs might have value in the treatment of thrombo-ulcerative colitis. Preliminary trials of such drugs have been encouraging. Sulfanilamide, however, has been found to be too toxic for it to find favor in the treatment of those types of the disease in which help is really needed. Several other forms of sulfanilamide have been tried without much more success, but the recent, less toxic neoprontosil has produced striking results in a small series of mild to moderately severe cases. This drug has been administered in doses as high as 75 grains (5 gm.) a day (divided into 5 doses) over a period of weeks with complete abatement of symptoms and striking improvement in the appearance of the lining of the bowel as viewed through the proctoscope.

Many of the measures suggested here for thrombo-ulcerative colitis are applicable also to cases of ulcerative colitis of unknown etiology.

### Ulcerative Colitis of Unknown Etiology

One cannot stress too greatly the importance of intensive further study in cases of intestinal ulcerative disease in which the etiology is not clear. Until adequate cause is found, the symptomatic program outlined will have to serve. Modifications will have to be made to suit the individual case. There is probably no other disease-provoking condition in which it is so important to treat the individual and not the disease. True enough, certain well regulated principles have been established in

the management of most cases of ulcerative colitis. Too frequently, however, such measures will fall far short if special emphasis is not paid to the symptoms in each individual case. Failures of treatment may be frequent, but they will be less and less frequent by strict adherence to a well ordered regimen.

It has been well said that disease above the diaphragm makes for optimism and below the diaphragm for pessimism. There is no group of diseases where this is better expressed than in the ulcerative types of colitis.

It is hardly possible to discuss the various types of colitis without mentioning the conditions associated with a deficiency of one food element or another. Sprue and pellagra are probably the commonest of these. It is important to determine, if possible, just what is lacking in any given case of deficiency and then treat the patient by supplying the food, mineral, or other substance which is causing the deficiency. In the case of active pellagra, a diet high in calories and vitamins is probably the most important single measure in the treatment; supplying all the necessary food elements, and at times supplying more than adequate quantities, may be enough to control the condition. At the onset, an excess of vitamin B should be given, using it in concentrated form. Nicotinic acid has recently been found to be particularly valuable. In the case of sprue, the factor of anemia is frequently one which must be dealt with very drastically; hence the administration of some of the drugs used in the treatment of anemia may be indicated. Liver extract, preferably given hypodermically and in large doses, is of value. Dilute hydrochloric acid adminis-

tered by mouth may be advisable as a substitute for the acid which may not be present. A diet rich in carbohydrates, high in proteins and relatively low in fats has proved most efficacious. Frequently even carbohydrates are poorly tolerated at the onset and must be added slowly. Deficiencies may be secondary to any other bodily state that may be associated with diarrhea. Such conditions are usually best managed by control of the basic pathologic changes.

One must also keep in mind the great importance of regional colitis in which short segments of the intestine are involved by an inflammatory disease much in the nature of so-called regional ileitis. The best method of diagnosing this condition is by careful roentgenologic examination. At present, the accepted and most successful form of treatment seems to be surgical resection. Diarrhea may also occur with various local granulomatous processes such as infectious granuloma; again, surgical resection seems to be the treatment of choice.

It is likewise difficult at times to differentiate the various forms of colitis from the infectious dysenteries. Typhoid fever or bacillary dysentery can be differentiated by adequate blood cultures and serologic agglutination tests. If these conditions are suspected, precautions should be taken to isolate such patients.

In summary, one might say that the various forms of colitis and conditions associated with dysentery present some of the most serious problems which face the physician. One must ever be on the alert for them and the importance of differentiating between them so that adequate treatment may be established cannot be emphasized too greatly.



## CORRELATION OF CLINICAL AND LABORATORY DATA IN DISEASES OF LYMPH NODES\*

RAPHAEL ISAACS, M.D.

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Theoretically, a biopsy study of a lymph node affords the most certain method of diagnosing the type of lymph gland disease. Clinically, this method of study is not always feasible or desirable. At times it is necessary to know something of the nature of the disease before a biopsy report could be obtained. There are some features of the clinical examination which correspond to, and suggest, certain histological changes in the lymph nodes.

The most common types of lymphadenopathy are those found in (a) local or (b) general pyogenic infection, (c) tuberculosis, (d) infectious mononucleosis, (e) Hodgkin's disease, (f) sarcomatous Hodgkin's, (g) lymphosarcoma, (h) metastatic neoplasm (carcinoma), (i) syphilis, and (j) leukemia. Other and less common types may be noted.

For the present purpose, the lymph nodes may be considered as being composed, primarily, of growing lymphocytes (large and small: young and old) in a capsule of connective tissue. In addition to this there are various types of connective tissue and stroma cells, plasma cells, eosinophiles, nerve cells and fibers, blood vessels and circulating blood cells of the usual types.

An individual lymphocyte is very soft. A red blood cell will indent its edge. When the gland is filled with lymphocytes, the gland is soft. This is the condition in lymphatic leukemia. Connective and fibrous tissues are comparatively hard. When these elements are increased in amount in Hodgkin's disease, the node is hard, or when a gland recovers from a chronic infection the fibrosis is reflected in the increased firmness. When the center of the node becomes semifluid, as when pus accumulates, the sensation of fluctuation can be obtained. When cells, having but little cytoplasm, increase in number, the glands become very firm, as in lymphosarcoma, and when carcinoma cells invade the tissue, a stony hardness is noted.

When a gland enlarges slowly, it is not tender or painful. A rapidly enlarging gland stretches the capsule, and this affects the nerve endings. The most common type of rapid enlargement with tenderness is

found in acute infections, such as regional lymph nodes in furunculosis, or the nodes early in infectious mononucleosis.

As long as the capsule and surrounding tissue are not involved in the disease process, the gland is freely movable. In lymphosarcoma the neoplastic cells invade the capsule and enter the surrounding tissues. This makes the gland adhere to the surrounding structures. In infections there is a periglandular reaction which has the same effect. In pyogenic infections, the overlying skin may be reddened. In tuberculosis, the gland may become adherent to the skin and a sinus may follow rupture. A pus-filled gland may become attached to the surface and rupture, forming a draining sinus. The other types of lymphadenopathy do not show this characteristic, although it may appear if a secondary process develops, as necrosis of an adherent sarcomatous node. When the capsule is involved, the glands may become adherent to each other, forming matted masses. In Hodgkin's disease the glands remain discrete until close packing of the hypertrophied nodes causes them to adhere to one another. In syphilis and lymphatic leukemia, the nodes remain discrete. In the sarcomatous form of Hodgkin's disease, cells penetrating the capsule invade the surrounding tissues and simulate the condition in lymphosarcoma.

The location of the enlarged nodes may be of diagnostic significance. Usually, only the neoplastic forms (lymphosarcoma, sarcomatous Hodgkin's, leukemia) give lymphoid nodules in places where normal nodes are not common, as scattered over the skin of the trunk or extremities. Enlargement of the tonsils, in generalized lymphadenopathy, most frequently suggests lymphosar-

\*From the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan, Ann Arbor. Delivered before the American College of Physicians, New York City, April 7, 1938.

coma, less frequently syphilis or carcinoma. Inflammatory involvement of the tonsils, with exudate, may characterize acute leukemia or infectious mononucleosis. In carcinoma and tuberculosis, the lesion is more likely to be local than generalized. The spleen may escape gross enlargement, at least until the last stages, in lymphosarcoma, whereas it is commonly involved in leukemia, Hodgkin's disease, syphilis, and infectious mononucleosis. It may, however, be involved in any of the other conditions if the process is generalized.

Gross anemia, as evidenced clinically by pallor of the mucous membranes, is most common in advanced Hodgkin's disease and leukemia. It may be present in bleeding carcinomas, or at the terminal stages of lymphosarcoma.

Fever may be present in the infections, in infectious mononucleosis, at times in Hodgkin's disease, tuberculosis and leukemia; seldom, unless there are complications, in carcinoma, lymphosarcoma, or syphilis.

Purpura or bleeding areas around the gums or elsewhere, is most likely to be present in leukemia. Maculo-papular and erythematous skin eruptions may be present in German measles and in infectious mononucleosis. Nodular eruptions, with induration of the skin, macular infiltration and cutaneous hemorrhages may be present in leukemia or lymphosarcoma. Pigmentation and exfoliative erythroderma may be present in Hodgkin's disease. Herpes is present occasionally in leukemia.

Stomatitis may be present in acute leukemia, in chronic monocytic leukemia, infectious mononucleosis, and syphilis.

Before one takes up the microscope, several additional possibilities may develop from a study of the history. The suddenly enlarging tender node with overlying reddened skin following localized trauma and infection is to be distinguished from the slowly growing non-tender unilateral enlargement which later becomes bilateral, as in Hodgkin's disease, or may remain asymmetrical, as a carcinoma. The family his-

tory of tuberculosis may give one a clue. In Hodgkin's disease, sarcomatous Hodgkin's and lymphosarcoma males are more frequently affected than females. Infectious mononucleosis is more likely to occur in children and young adults than in the middle ages; tuberculous lymph nodes in the young; Hodgkin's disease most commonly between the ages of twenty and thirty.

These points suggest a few of the data which may be obtained from the study of the patient when laboratory aids are not at hand. The blood, of course, would be very helpful in leukemia (immature cells), in infection (basophilia of the granules of the neutrophils), in lymphosarcoma (characteristic cells), infectious mononucleosis (characteristic cells, sheep red blood cells agglutination), and in syphilis (serologic tests). In any disease of lymph nodes, plasma cells may appear in the peripheral circulation.

The biopsy examination usually gives a definite answer in Hodgkin's disease, tuberculosis, syphilis, carcinoma and lymphosarcoma. Removal of individual lymph nodes is not entirely devoid of danger. In lymphosarcoma recurrence of the lesion in the biopsy wound is common. Secondary infection is not uncommon, as cases who have come to us with infected biopsy wounds amply demonstrate. Removal of single nodes appears, in some cases, to activate Hodgkin's growths. Sinus formation has followed removal of individual tuberculous glands. Finally, a normal, not yet affected node is sometimes removed, when others in the body show the disease lesion. These are chance incidents, however, and do not invalidate the diagnostic importance of biopsy examination.

*Conclusions.*—On examination of the patient, it is possible to note many physical features which are secondary to, or associated with, histological changes in the lymph nodes, at times sufficient to make a definite diagnosis before the aid of the laboratory is available.



# LYMPH GLAND REMOVAL IN CANCER OF THE CERVIX

## Technique and Results.

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For the past fifty years the efforts to effect a cure in cancer of the cervix, limited as they are to surgery and radiation therapy, have been directed along two lines: (1) to remove or eradicate the cancer that may have extended to the connective tissue or organs around the cervix; (2) to remove or eradicate the cancer that may have metastasized to the tributary pelvic lymph glands.

During the first half of this period, up to 1913 let us say, treatment consisted almost entirely of surgical excision. Toward the end of the nineteenth century two Viennese gynecologists, Schauta and Wertheim,

devised operations for the radical removal of the entire uterus and appendages, upper vagina and surrounding pelvic connective tissue. Schauta, working from the vaginal route, could not remove any lymph glands, whereas Wertheim, through an abdominal incision, could take out some of the glands, but by doing so added to the trauma and length of the operation and thus had a higher operative mortality. In the very early cases such a combined hysterectomy and gland removal was reasonably safe but in slightly more advanced cases with partial parametrial involvement it was impossible to include the gland removal without increasing the operative mortality to 15 or 20 per cent. It was this high primary death-rate that induced many gynecologists to abandon surgery except for the early cases, especially as it became more and more evident that radiation treatment in cervix cancer was very effective in eradicating the disease and was attended by about one-tenth the mortality.

This swing away from surgery to irradiation in the treatment of cervix cancers from 1915 to 1930 became so widespread that only here and there a few gynecologists could be found to continue with the difficulties of the radical operation. In England, Berkeley and Bonney, and in this country, Graves, Lynch, Gellhorn and myself, have adhered to surgery in suitable cases. In Group I cases (League of Nations classification) the operative mortality, especially if the cancer was cleaned up by preliminary radiation, did not rise much over 6 to 8 per cent. When, however, cases with pal-

pable parametral thickening (Group II cases) were subjected to such a pan-hysterectomy the mortality, as shown in Bonney's series, jumped to 12 or 15 per cent.

The average distribution of the four groups, when the League of Nations is strictly adhered to, is as follows: Group I, 15 per cent; Group II, 28 per cent; Group III, 34 per cent; Group IV, 23 per cent. It will be seen from this that there are almost twice as many Group II cases that come to us for treatment as Group I cases. In these relatively less advanced cases irradiation with x-ray and radium produced very satisfactory regression in almost all cases and cures for five years or more in about one-fourth of them. Where recurrences took place, as Regaud and others have pointed out, the site was apt to be in the pelvic lymph glands, tributary to the cervix.

In 1930, Dr. Gellhorn and I were trying out a method of intra-abdominal radon seed implantation for Group II and Group III cancers and in the course of such an operation in October of that year I found a markedly enlarged hypogastric gland which could easily be removed and proved to be carcinomatous. The gland on the other side was not malignant. This patient, by the way, is still free of recurrence almost eight years later. In the course of the succeeding months I gradually developed the operation of iliac lymphadenectomy and carried it out in an increasing number of cases. The idea back of this procedure was to treat the disease in the cervix, upper vagina and parametrium by irradiation and to re-

move surgically the tributary lymph glands in the pelvis as far as this was technically practical. I also tried out the operation in a few Group III advanced cases, but found that my operative mortality in this group was prohibitively high (three out of eight). Since 1933 I have restricted the operation to the Group II patients.

It has been universal experience that radiation therapy is very unsatisfactory in eradicating cancer metastases in lymph glands. In cancer of the oral cavity, the breast, the vulva and penis even though the tributary lymph glands are relatively superficial, radiation has been very disappointing, especially when compared to surgical excision. Hence, the accepted treatment in these forms of cancer has long been the radical removal of the lymph gland chains. It seemed logical, therefore, to try out a similar procedure in cervix cancer. The crux of the problem was how radical this lymph gland removal could be made without increasing the primary mortality. I had the conviction that if we could keep this operative mortality below five per cent, the procedure should give long-time results that would justify its performance. For this reason I have never attempted the removal of the inaccessible sacral glands, which according to careful autopsy studies are not involved in more than three per cent of cases. It was also felt inadvisable to include glands near the aortic bifurcation since an extension to this point indicated widespread metastasis. The glands removed, therefore, were primarily the so-called first-stage glands, the hypogastric and obturator group, also those along the external iliac vessels, including in recent years the ones near the inguinal ring, and finally, whenever palpable, the ureteral gland (Championnier).

The foundation for our knowledge of lymph-gland metastasis in cervix cancer dates back to the intensive studies made in Germany between 1900 and 1910 largely as a result of the rivalry between the followers of Wertheim and Schauta. Roughly summarizing the experience of a variety of gynecologists we see that in Group I cancers the glands showed metastases in 25 per cent; in Group II cancers, the involvement was about 40 per cent; Group III, 55 per cent; and in Group IV (that is to say, those who died of cancer and came to au-

topsy) the involvement according to Schauta's 50 cases was 64 per cent.

As to the location of these metastases it was observed that about two-thirds of them

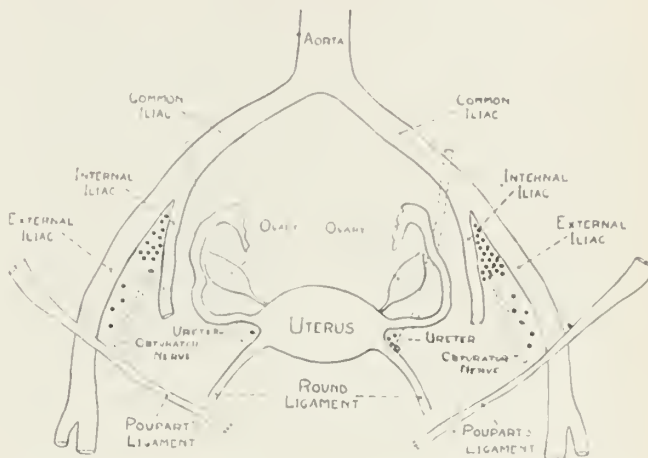


Fig. 1. Distribution of lymph-gland metastases in cancer of the cervix.

were in the hypogastric and obturator glands. The sacral glands were involved in about five per cent of the metastatic glands. The ureteral gland or gland of Championnier in about 8 to 12 per cent and the glands along the outer border of the external iliac vessels and higher up in the abdomen in the remaining 18 per cent. These figures may need slight revision in further studies but are approximately correct.

My own figures in eighty-three Group II lymphadenectomies showed metastases in twenty-nine cases (35 per cent). In seven of these cases cancerous lymph glands were found on both sides. The distribution between the two sides showed an unexplainable difference, thirty on the left side compared to eighteen on the right. The hypogastric glands were involved in 68 per cent of the cases. Details of the distribution of cancer metastases are found in Figure 1.

Coming now to a discussion of operative technic, it was inevitable that with increased experience in a new procedure of this kind there was some modification and improvement. The most important change made in the last four years was the complete separation of the radiation treatment from the operation itself. Originally the radium or radon seeds were applied to the cervix at the time of the operative removal of the lymph glands. When this was done, the post-operative course was stormy and the only two fatalities occurred during this period and with reasonable likelihood were due to



the associated radiation. In one of the 1931 series in which radon seeds were implanted close to the uterine veins, the patient died suddenly on the ninth day of an embolus.

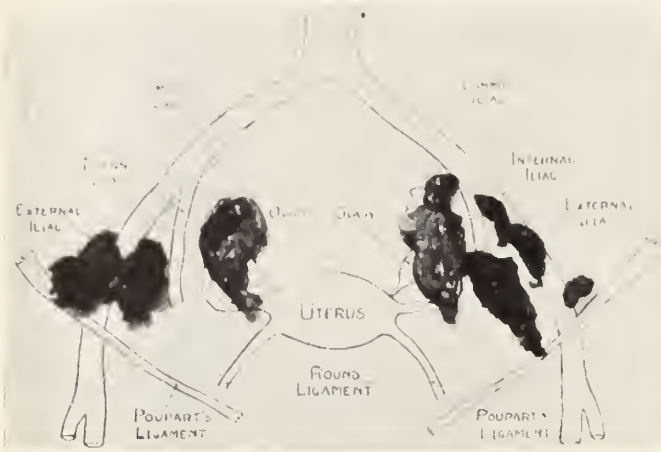


Fig. 2. Lymph glands, together with adnexa, removed by iliac lymphadenectomy for cervix cancer, photographed according to location.

In another case, the thirty-fourth in my series, radium applied to a uterus whose walls were weakened by the removal of a rudimentary horn caused an infection of the parametria and led to a fatal peritonitis. For the last sixty lymphadenectomies no such combination with radiation has occurred and by a lucky chance not one post-operative death has occurred. Accordingly my operative mortality in the entire series of ninety-five Group II lymphadenectomies has been only 2.1 per cent. I must confess, however, that four of these patients had severe operative hemorrhages and were in serious condition. A longer series of operations may slightly increase my mortality. My experience, however, is definite proof, I believe, that no one can maintain that this operation is not justified because of its operative risk.

At present my technic consists of a course of deep x-ray treatments, totally about 6,000 r units, to the skin over four portals over a period of about two weeks, followed two weeks later by the lymphadenectomy. Two or three weeks after operation radium is applied to the cervix. In some instances the radium treatment to the cervix has preceded the lymph-gland operation. The dosage with radium has averaged 4,500 mg. hrs.

The operation begins with the removal of the tube and ovary to gain better access to the lymph-gland-bearing area. It is interesting in this connection to note that two

French surgeons, Leveuf and Godard, have also advised a lymph-gland removal for cervix cancer. They start with a section of the round ligament to give access to the deeper tissues. In 1933 they reported that in two cases they did such a gland removal following one month after radium treatment to the cervix. They state that their first case was done in July, 1930, so that apparently they can justly claim priority by a few months over my operation, even though their two cases prove nothing as to the value of this procedure.

With the adnexa out of the way, the leaves of the broad ligament are widely opened by the fingers, exposing the ureter clinging to the posterior sheath and the large iliac vessels on the side of the pelvis. Cleaning off the loose fat, the angle between the external and internal iliac vessels is palpated and the gland at this point gently loosened from its attachment by digital pressure. When it can be clearly seen, tributary veins are clamped and cut and the gland removed. By this time the obliterated hypogastric artery is seen running toward the bladder and as the finger passes beneath the external iliac vein the obturator gland and its surrounding fat can be felt and lifted clear of the obturator nerve which often runs through the center of this mass. Again under the guidance of the eye, tributary veins are clamped and cut and the long obturator gland followed almost to the femoral ring before its end is released and nutrient vessels caught. Palpation at the point of crossing of ureter and uterine vessels will reveal a gland if it is enlarged. Its removal is not so simple, as venous bleeding and possible injury to the ureter must be guarded against. Duncan has suggested routine ligation and cutting of the uterine vessels. I have not done this routinely as in difficult cases it may stir up deep venous hemorrhage. In the last three years I have regularly exposed the external iliac vessels along the pelvic brim and removed the gland just beneath the inguinal canal which can readily be exposed and easily removed. Occasionally a gland will also be found over the bifurcation of the common iliac vessels or between the external iliac vessels and the psoas muscle. One must expect certain abnormalities of lymph-gland distribution, but with increased experience more and more lymph glands will be found. The finger

TABLE I.

Survival years	Voltz	Gellhorn	Taussig
	Radiation alone 310 cases Percentage survival	and Taussig Radiation alone 76 cases Percentage survival	Radiation and lymphadenectomy 30 cases Percentage survival
1	65.5	52	66
2	36.4	41	56.6
3	27.7	31	
4	22.9	25.5	
5	22.3	20	50 (10 cases)

must be trained to coöperate with the eye in this search (Fig. 2).

After removal of the lymph gland has been accomplished on both sides, the wound is closed with a minimum of dead space by suturing the round ligament to the sacro-uterine, catching both at a point about one to two inches from the side of the uterus. The peritoneum is then closed by a running stitch. The whole operation should not take over an hour exclusive of the incision. Spinal anesthesia has been usually employed on account of the complete relaxation of intestines and hence better exposure of the pelvic region.

Complications consists primarily of injury to the ureter, which has occurred twice, and hemorrhage of the deep pelvic veins, which in three instances became so uncontrollable that clamps were left upon the larger vessels and the tissues packed with gauze. Removal two to three days later was uncomplicated by bleeding or infection. Three times the external iliac vein and once the external iliac artery had to be ligated to permit the removal of large adherent glands. No post-operative edema or difficulty was experienced in these four cases.

The final answer to the value of iliac lymphadenectomy in Group II or borderline cancer of the cervix cannot yet be given but with each year of experience we are becoming more encouraged, not merely as to the immediate low operative mortality but with each year of experience we are ber of operations done has considerably increased in recent years owing to the enlargement of my service at the Barnard Free Skin and Cancer Hospital where almost all of these cases were operated on.

By years they were:

1930	2 cases
1931	6 cases
1932	6 cases
1933	4 cases
1934	10 cases
1935	8 cases
1936	22 cases
1937	13 cases
1938	24 cases

One of these operations was done at the University of California Hospital through the courtesy of Dr. Frank Lynch. It should be stated that Dr. Lynch in San Francisco, Dr. Victor Bonney in London and Dr. Duncan in Brooklyn have done a series of iliac lymphadenectomies.

The survival rate of these cases will alone give us a fair impression of the value of this operation. Comparison must be made with a series of Group II cervix cancers treated by radiation only. This was made possible at the Barnard Hospital by the fact that Dr. Gellhorn, who shared the service with me from 1930 until his death early in 1935, treated this group of cases by radiation alone. We also have available figures of survival rates in a large series of Group II cancers treated only with radiation by Voltz in Germany. In addition to Dr. Gellhorn's cases I also had a small number of Group II cases which because of obesity, old age, or other operative contra-indications were treated by radiation alone. Table I shows the percentage of survivals over a period of one to five years and I think demonstrates the value of this operation.

In the course of the next two years when we have a greater number of cases that have passed the five year period, we shall be able to speak with more authority on our



results. For the present we can only say they are promising. An increase of 15 per cent in the group of two-year survivals and an increase of 30 per cent in the five-year survivals certainly justifies whatever cost and discomfort the additional operative procedure may have entailed. The real value of the lymph gland removal can better be visualized in the five-year survival rate than in the two-year period. Local recurrences due to failure of regression in the cervix would be apt to show themselves in this period and would apply to either

group, whereas the gland metastases would usually show up somewhat later, so that the difference in the survival curve should be expected to be greater between the two- and five-year period.

With the low operative mortality of two in 95 cases (2.1 per cent) the safety of the operation has been proven. It remains now only to show on a larger scale that we can, as seems probable at the present time, save twice as many Group II cancers by this procedure, to justify completely its performance routinely in all clinics.

## HEARING AND DEAFNESS\*

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Hearing may be defined as the ability to comprehend speech, deafness as an interference with this comprehension. These definitions are neither technical nor complete. They, however, serve to emphasize aspects of the hearing problem that physicians frequently overlook. Patients never complain that they can no longer hear the overtones of the flute or of the piccolo. It is the inability to hear social or business conversation that causes them to seek advice. The loss of hearing for high notes may be mentioned but this is not a major complaint, even among those interested in music. Comprehension of speech involves not only

an adequate hearing organ in the temporal bone but also an intact and agile central nerve mechanism. Everyone recognizes that it may be necessary to repeat a statement to an old person several times before it is understood. Raising the voice may focus the wandering attention of the aged, but the hearing acuity may not require this increased volume.

The range of sounds heard is conveniently tested by using pure tones generated by an audiometer. When tested in this manner a patient may have a normal curve of hearing acuity. The patient in this test is required merely to say that he hears or does not hear the sound. Extensive comprehension is not required. By testing the acuity for connected speech with the aid of a phonograph and a calibrated volume control some patients may show a slight hearing loss. Substituting isolated numbers for connected speech with such patients the loss

may be much greater. These individuals have a good end organ of hearing but are lacking in their attentive faculty. For practical purposes they are partially deafened and they may complain of deafness. This phenomenon, and not the loss of hearing for high tones, accounts for many of the complaints of deafness of old persons. The physician must realize that the approach of these cases is not a strictly otologic one. A hearing aid for older persons sometimes defeats its purpose by increasing the fatigue of the attention.

While the ear with acute hearing can appreciate nine or ten octaves, the hearing necessary for speech requires but about three octaves. The best speech perception requires a greater range but these few octaves serve rather well. The clarity of speech reproduced by the small radio and the commercial telephone testifies to the adequacy of a small range. In the light of the foregoing comment I trust that my unorthodox defini-

\*Read before the seventy-third Annual Meeting of the Michigan State Medical Society, Detroit, September 20, 1938.

tions will be accepted for their practical worth.

With increasing years our ability to hear high notes decreases. However, this deafness for high tones may be found at any age. Unfortunately this is many times accompanied by a tinnitus in the range of the missing frequencies. In almost every group of medical students there is at least one person who does not have a sense of hearing for high notes. A typical example is the student who does not hear the three highest notes on the piano. This may seem a handicap until we reflect that to most people the upper piano octave has little musical quality.

Everyone will recall Galton's interesting experiments with a whistle concealed in his walking stick. When he set the whistle for its highest tones he attracted the attention of young humans and young animals. Older beings, not hearing the sound, were not disturbed. The so-called silent dog whistle is an adaptation of the Galton whistle. It takes advantage of the better appreciation of high notes by the dog than by the human. This almost physiological upper tone loss with age does not affect the comprehension of speech until the loss encroaches upon the lower frequencies. This is a typical perceptive hearing loss. The mechanism of the middle ear (drum membrane and the ossicles) may be intact. The tests for low tones may be normal.

When a perceptive deafness is found in children it frequently has a very irregular character. There may be only an island or two of hearing. This deafness may date from birth or it may have developed without any objective signs of disease. Other children have definite histories of such conditions as meningitis. With an extreme hearing loss these children require special training to learn to speak, to preserve their speech, and to acquire auxilliary faculties to compensate for their hearing loss. In the care of all of these cases of perceptive deafness a peculiarity for this type must be remembered. When heard at all loud sounds are just as unpleasant as they are to the normal hearing individual. Due to the studies of Pohlman and Krantz, Rieger, and Fowler, we have a partial understanding of this phenomenon. It may be better understood by referring to the chart on which the audiogram is recorded. The upper heavy

line indicates the threshold of hearing. The lower dotted line indicates the intensity at which the loudness becomes painful and hence useless for hearing. In testing, tones are increased in volume until heard. Once the tone is loud enough to be heard, the sensation of loudness is almost the same as for the normal ear. It is as if the ability to hear weak sounds had been wiped out with but little change in the hearing of loud sounds. This has an important bearing upon the use of electrical hearing aids for it limits the amount of amplification useful to the patient.

Contrasted with these patients are those whose end organ of hearing and whose central connections appear to be normal. Deafness is due to some hindrance to sound reaching the end organ in the cochlea. This group includes those suffering from active middle ear disease, those with scarring in the middle ear, and those with otosclerosis. There is good reason to believe that once sounds reach the cochlea in these cases the hearing is essentially no different from that of a normal individual. We noted that those with a perceptive deafness had lost a certain portion of the spectrum of hearing. We also noted that within their hearing range they behaved much like the normal individual. With these conductive deafened cases it is as if the hearing spectrum had been depressed on the chart by an amount equal to the impedance factor of the obstruction. In an active infection this means that sound travels with difficulty through the collected secretions. In otosclerosis this means that the transmitter, the drum membrane and the ossicles, which converts sound waves in air to sound waves in fluid no longer functions. Apparently the shades of pitch and volume are the same as if a normal individual heard them from a great distance. Sounds when amplified seem normal to these patients. The individual with this type of deafness receives great benefit from the electrical hearing aid and also enjoys listening to radio programs if the volume of the receiver is increased enough to overcome the obstruction in his middle ear. The perceptive deafened individual, previously discussed, gets little enjoyment from increasing the volume for to him the loud sounds are painful.

In the foregoing the problem of deafness has been made too simple. Many observed



clinical phenomena do not fit well into such a simple exposition. Moreover, many patients show evidence of both a conductive and a perceptive deafness. For example, in middle ear infections part of the deafness may be due to a toxic depression of the hearing end-organ. No doubt the diagnosis of mixed deafness is justifiable in order to clearly state such findings. Such a diagnosis should not be used to cover an inadequate examination.

As far as the diagnosis of mixed deafness is concerned, a decision should be made as to the major disabling lesion. This leads to clarity of clinical thought. This does not mean that, in a true case of mixed deafness, the major disability of which is due to a perceptive lesion, the conductive lesion should not be treated. A small increase in hearing acuity may be of inestimable value to the patient. At the present time less hope can be offered to those suffering from a perceptive lesion. In perceptive deafness there may be an apparent improvement under drug and diet therapy and even a justification for considering that a focal infection may cause part of the trouble. Any remedial régime must be carefully considered. The indiscriminate recommendation of nasal operations and tonsilectomies as possible remedies for deafness has brought little credit to the medical profession. Patients with a congenital perceptive deafness frequently state that their tonsils were removed to improve their hearing but that no improvement resulted. Deafness should not be an indication for tonsilectomy. The decision for surgery or medical treatment of the rhinopharynx must rest on the conditions observed in the rhinopharynx.

A conductive deafness due to an infection may improve with treatment which promotes a recession of the infection. Even conductive deafness due to otosclerosis may be amenable to treatment in the near future.

As suggested at the beginning deafness for practical purposes includes those cases that fail to comprehend speech because of some difficulty in the central mechanism. The diagnosis of mixed deafness when loosely made includes many of these cases. The treatment of these cases is not a truly otologic problem.

The accurate diagnosis of the hearing lesion is a time-consuming and technical procedure. This should not deter the general

practitioner from making a brief survey of the hearing and it should be no excuse for the use of careless methods in this brief survey. The voice of the patient gives some indication of the type of deafness. The harsh, loud, unmusical voice probably belongs to the patient suffering from a perceptive lesion. The patient is unaware of his vocal shortcomings because he is deaf for those frequencies in which they occur. His own ears cannot correct the defects. The deaf patient with a low, well modulated voice is typically one suffering from a conductive lesion. The lesion has produced an effect similar to the occluding of both ear canals with fingers in a normal person. The normal voice under these conditions is inordinately loud and the patient adjusts the volume of his own voice to the comfort of his own ears.

The examination with tuning forks is both well known and well described. The general practitioner may be justified in certain simplifications of some of these tests. It is obvious that the various tests comparing air conduction with bone conduction are merely modifications of the Rinne test. In brief examination it is not necessary to investigate hearing at all frequencies. If the physician has a tuning fork of a high pitch such as 4096 and if he knows his own hearing time to be normal for this frequency, he can readily determine the recession of the hearing for high notes by determining the length of time which this fork is heard under a fairly well standardized exciting blow. A single other fork of 256 or 512 double vibrations should suffice for the Weber and Rinne tests. Here the patient must distinguish, especially with the 256 fork, between vibration sense and hearing. The tuning fork must be carefully selected. In one clinic in which I work there is a tuning fork that gives bone conduction greater than or equal to the air conduction in the normal patient. The hearing time for bone conduction and for air conduction is dependent upon peculiarities of the individual tuning fork. With any tuning fork its characteristics should be known. The carrying out of the fork tests and of the electrical audiometric tests is a medical problem. It should be remembered that if a commercial firm offers to test the hearing of a patient the test is being conducted by nonmedical persons. Although some of

these tests may be excellent and the results useful, such a situation is bad in principle. There are several pitfalls to be guarded against in a brief examination of hearing. A clever, self-taught lip-reader visited a clinic for nasal treatment and was seen by several physicians before it was discovered that she had no hearing for conversation at ordinary volume. In examining a patient complaining of deafness one should eliminate the lip reading factor by holding a card or fan before the examiner. A noisy examining room is a distinct handicap. The examiner being conscious of the noise raises the level of his own voice so that he may hear himself speak. The deafened patient, especially if of the conductive type, will not be influenced by the masking effect of the high noise level and will hear the loud voiced examiner with ease. Another pitfall is met in those cases that date their deafness to an accident or to a severe illness. This is even credited occasionally in medical literature. The hearing loss may be of such a character that there can be no relationship between the trauma and the deafness. Up to the illness or injury the patient had been able to compensate in part for the hearing loss. With the compensatory mechanism reduced by malaise the hearing loss became quite obvious. Other patients report that every time they have a cold their hearing decreases. This is due to an actual lesion of the middle ear and eustachian tube or due to the malaise cited above. In the same category is the complaint of the secretary who has difficulty with dictation during the menstrual period. The hearing difficulty is constant. The period of cyclic depression reduces the ability to compensate for the hearing loss.

To stir up wide interest in the problems of the deafened the slogan "deafness can be prevented" has been broadcast. This is unfortunate for many times it is not true in any practical sense and the self-accusing parents should be reassured.

The handling of a hearing case can be considered under the following heads: diagnosis, treatment if indicated, provision of a hearing aid, if useful, and adjustment of life to the deafened state. The physician must participate in all these. The otologist is refining the matter of diagnosis. Careful evaluation of treatment indicates the present still unsatisfactory state. The tech-

nical developments in hearing aids can not be used to their fullest extent because of the prejudice of patients.

The hearing aid properly selected may be of invaluable assistance to the adult in carrying on in the field in which he is already trained. The hearing aid occupies a still more important position in the training of the deafened child. Much effort and money is expended upon the education of the totally deafened. There are a large number of children in our public schools, however, whose hearing is depressed to such a point that they have difficulty in keeping up with routine class work in competition with normal-hearing children. For these children some of the more newly developed hearing aids which are actually small amplifying systems are of great value. These are capable of picking up speech from distances of 20 to 40 feet. Certain children, as do adults, object to the use of an obvious hearing aid. The very use of hearing aids in the schoolroom will help break down the prejudice by educating the public in their use.

Deafened children must be trained for suitable occupations. The large number of physicians wearing hearing aids is adequate testimony of the fact that deafness is compatible with the practice of medicine. It is not unusual to find a medical student wearing a hearing aid. Certain of the medical specialties may not be pursued as readily as others. One hospital resident who was considering cardiology but who thought that his hearing was slightly deficient, gave up the idea of cardiology when careful examination confirmed his suspicions.

Obviously stenography and salesmanship do not adapt themselves to the deafened. Bookkeeping is a possible field. Nursing is not suited. The trainees may be able to meet the requirements in most departments of the hospital but they have an insurmountable difficulty in the operating room where the wearing of masks precludes the possibility of lip reading. It might seem that the field of occupational therapy would afford opportunities for the deafened. Due to the peculiar reactions of the ill and disabled the supervisors of training of occupational therapy workers do not feel justified in accepting handicapped individuals. The contact between the occupational ther-



apists and the patient generally turns into one in which the patient is endeavoring to aid the handicapped occupational therapist rather than the reverse.

In the training of children with a severe grade of hearing loss it is very important to make use of such residual hearing as they may have. This slight remaining hearing permits the child to develop a rhythm to speech and permits the development of a smooth, musical quality. The contrast between a child with very little hearing and a child with no hearing is remarkable. In both of these instances the training of the speech organs has to be based on an imitation of the tongue positions and the use of the breath as demonstrated by a teacher. If to this nonaural demonstration there can be added a small amount of imitation of sounds, much improvement is obtained.

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### RECENT RESEARCHES IN NUTRITION IN RELATION TO PREVENTIVE MEDICINE

NINA SIMMONDS, San Francisco (*Journal A.M.A.*, Sept. 17, 1938), concludes her discussion of nutrition in relation to preventive medicine by saying that the practical application of research in nutrition during the past twenty-five years has been not only to emphasize the value of sunshine and fresh air but also to give the reasons why in a system of diet the following familiar foods have unusual dietary significance: meats, including glandular organs, poultry and fish; eggs; milk in its many forms and products; fruits and vegetables (fresh, canned and frozen); legumes, and cereals and their products, especially whole grain products. Research has provided vitamin capsules, vitamin tablets, brewers' yeast tablets and numerous other vitamin preparations, many of which are excellent supplements to a diet when certain foods are disliked, but one should know what they do not contain as well as what they do contain. Nutrition has been referred to as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology." However, because of the results of recent researches on diet and its relation to disease conditions, from the standpoint of preventive medicine and of public health, nutrition may now be considered largely a problem of economics and education.



# LOW ILEUM INTUSSUSCEPTION CAUSED BY MECKEL'S DIVERTICULUM

## Report of a Case

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Acute obstruction of the small intestine, due to intussusception, is a fairly common condition in children under the age of five. From 40 to 75 per cent occur under one year of age. In adults intussusception is not only rare but one of the most fatal abdominal catastrophes. It arises in a variety of ways and gives rise frequently to bizarre symptoms. This condition most often defies recognition and is treated by various surgical and non-surgical methods.

Intussusception is defined as the entrance of one part of the intestine into another. It is nearly always an upper portion that enters into the lower. The intussusception does not enter into the intussuspiens alone, but carries with it its mesentery, so that there is marked interference with the blood supply of the inner segment, and the swelling which follows causes complete obstruction of the bowel.

The most frequent seats, according to Leichlenstern's collected cases, are ileocecal invagination 212 (44 per cent), ileum into ileum 142 (30 per cent), colon into colon 86 (18 per cent), ileum into colon 39 (8 per cent). Fitz collected 295 cases of intestinal obstruction; of these, 93 were due to intussusception; 52 were in males, and 27 in females. Pilz collected 293 cases, showing that 158 occurred in the first year of life. In 1911 Eliot and Corscaden reported 300 cases of intussusception in adults, 100 (33½ per cent) were due to a tumor. Of these tumors 60 per cent were benign polyps, fibroma, lipoma, papilloma, myo-adenoma, myxofibroma, and 40 per cent were malignant carcinoma, sarcoma, melanotic epithelioma. Most of the benign types of tumors originated in the inner layers of the intestinal wall and usually were constricted or pedunculated.

Ileum into ileum intussusception, due to Meckel's diverticulum, being a rare condition, it would, therefore, seem that the following case is of sufficient interest to justify its report.

### Case Report

*Case 1.*—Mr. C. C., a farmer, aged sixty-two, was admitted to the Ionia City Hospital, June 8, 1938, when he complained of abdominal pain and vomiting, which had been present for over four days. The pain was described as a "twisting," colicky nature, occurring in the lower right quadrant. On June 4, while he was cultivating a corn field in the afternoon, he felt a sudden severe abdominal pain

that started his vomiting. He was carried to the farmhouse a few hours later where a dose of epsom salts was administered, which he promptly vomited. The relatives noticed that the patient was gradually getting worse and brought him to the hospital. There was nothing in the family or personal history relevant to the present illness. He gave history of constipation, poor appetite, slight shortness of breath and tiring easily. There was no history of previous abdominal colicky pain, nausea, vomiting or intermittent attacks of "gas in stomach" or belching after meals. He never saw black or blood-stained stools, and no mucous or pussy discharge from the rectum. In fact he considered his health had been fairly good.

Summary of Physical Examination: General appearance of a poorly developed and undernourished male, weight 105 pounds, height 5 feet 2 inches, who appeared to be in acute abdominal pain. The skin was dry and slightly pigmented. Head, eyes, ears, and nose were negative. Mouth: had all his teeth removed because of pyorrhea. The tonsils were atrophic. Neck: revealed no cervical adenitis. The thyroid gland was not palpable and no associative signs of hyperthyroidism were observed. Chest expansion was free and equal, breath sounds were clear throughout, no râles heard, R.C.D. was not enlarged. The heart tones were distant but clear and no murmurs were heard. B.P.: 150/85. The vessel-walls were sclerotic. Abdomen: On inspection, no engorged veins, hernia, operative scars, or discoloration could be seen. However, noticed a slight peristaltic wave below the umbilicus. On palpation the liver and spleen were not enlarged. Kidneys were palpable but not tender. No tenderness over the gall-bladder region, but considerable tenderness in the lower abdomen. A tumor mass was felt at the lower abdomen just below the umbilicus slightly to the right quadrant, which was somewhat hard, movable, tender and not adhered to the abdominal wall nor did it appear to be a coil of intestine.

Laboratory Findings: Blood Kahn was negative. W.B.C. was 11,300. R.B.C. was 3,750,000. Polymorphonuclears 72 per cent. Urine examination revealed a one-plus albumin, but no cast, blood or pus.

Pre-operative Diagnosis: Acute intestinal obstruction.

Pre-operative Treatment: The patient was treated by Wangenstein's gastro-duodenal siphonage, enemas and adequate intravenous fluids, but his condition gradually became worse.

Operation: Under ether anesthesia, a midline incision was made, and when the peritoneum was opened, some blood-stained fluid was found, which



had a cadaver odor. A mass the size of an adult fist was felt under the distended coil of small intestine. Further investigation disclosed that the twisted mass was a part of the ileum which had entered into the lower ileum. Reduction was accomplished with some difficulty on account of the



Fig. 1. Gross specimen.

edematous bulk of non-viable intussuscepted ileum and its mesentery. About 22 inches of this intussuscepted bowel was released, and a diverticulum two inches long was found in the released ileum located about four feet from the ileocecal valve, which had caused the intussusception and obstruction. Intestinal resection was decided upon and about 25 inches of ileum and part of the mesentery were resected and end-to-end anastomosis was made. The patient reacted well. He was kept on Wangenstein's siphonage and intravenous fluids two or three days. On the fourth day the abdominal wound became severely infected, and all sutures had to be removed. The wound was irrigated by azochloramid isotomic solution 1-3300, and left to heal by granulation. The patient when discharged from the hospital on August 3, 1938, had recovered completely.

Postoperative Diagnosis: Acute intussusception of the lower ileum, and diverticulum.

Pathologic Report (St. Mary's Hospital Laboratory, Grand Rapids, Michigan). No. 14885. Gross specimen: Tissue consists of a mass of ileum approximately two feet long, containing a large diverticulum which apparently is obstructed. Microscopic sections: Sections from the mass of intestine show complete necrosis and loss of epithelium of the intestinal glands. Wall is almost completely necrotic. Diagnosis: Gangrenous small intestine with diverticulum. (Geo. L. Bond, M.D.)

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## LATENT LOBAR PNEUMONIA

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The diagnosis of a typical or manifest lobar pneumonia is seldom difficult. When there is a poverty of symptoms and signs so that both parents and attending physicians disregard and treat the condition lightly, then it presents interesting and unusual features which make it worthy of recording if only to call attention to this type, lest it reach epidemic proportions and lest serious complications and sequelæ develop.

Lobar pneumonia, particularly in older children, differs distinctly from that in infants, adults and in the aged. It is comparatively infrequent between the ages of five and twelve. The late winter and spring months show the greatest number of cases. The clinical manifestations are fewer and milder. There is no severe prostration and toxemia as in adults or infants. The physical signs may be indefinite or even entirely absent during the early days, and may not appear until the time of or even after the crisis or when complications are already present. The complications are infrequent; the prognosis is very good; the mortality

is less than five per cent and recovery is usually spontaneous and uneventful.

The explanation of the paucity of early physical signs has been furnished by roentgenographic studies. The size and extent of the pathologic process may be limited—a small area of lung tissue only may be involved without interfering much with respiratory function or pulmonary ventilation—thus no cyanosis and no dyspnea.

The location of the process may be high in the axilla with no communication with a bronchus. When the consolidation is localized in the depth of the lung or at the

symptoms cleared up the next day. The temperature continued 102°-104° for the next five days, with no other subjective or objective symptoms and signs. There were no symptoms referable to the respiratory tract. Physical examination of the chest



Fig. 1. Case 1. Anterior view, May 21, 1937. Right middle lobe pneumonia. True "central pneumonia." Sixth day after onset.



Fig. 2. Case 1. Right lateral view, May 21, 1937.



Fig. 3. Case 1. Anterior view, June 7, 1937. Complete resolution and resorption of pneumonic exudate.

root of the lung without reaching the periphery or surface "true central pneumonia"—recognition is most difficult. Physical signs become manifest only when the process communicates with a patent bronchus or reaches a large surface of the lung.

The lamentable latent periods of the roentgen method of examination are well known and recognized—as in bone diseases—particularly acute osteomyelitis. The limitations of the physical examination in lung disease are also well recognized. The clinical or physical latency of pulmonary tuberculosis has repeatedly been demonstrated by roentgen examination. That acute lobar pneumonia especially in older children may clinically and physically be latent at least for the first four to six days has been amply proved. A marked disproportion between the x-ray pathologic process and physical signs and symptoms may exist in acute lobar pneumonia as well as in many other chest diseases.

The following two cases observed by me within a period of two months are presented for record as latent lobar pneumonias:

*Case 1.*—A well developed white, female, aged nine, was in excellent health until the morning of May 15, 1937, when she awoke with a slight abdominal pain and a temperature of 104°. There was some slight sensitiveness in the right lower abdomen and she vomited once. The abdominal



Fig. 4. Case 2. Anterior view, July 16, 1937. Tenth day of illness. Resolving right upper lobe pneumonia. Resolution was complete ten days after this radiograph was made.

was essentially negative. She did not appear acutely ill. She was up and around. The general physical examination was essentially negative. The continued fever was unexplained. Several urine examinations were negative except for a few red cells. A blood examination May 17, 1937, showed a low total white count. The provisional diagnosis was grippe and she was so treated with simple nursing care. During the night of May 20 there was a profuse perspiration (probably the crisis) after which the temperature gradually subsided. It was normal May 24, 1937. A noticeable cough first developed



May 22, 1937—at first dry, then becoming productive. The cough lasted several weeks. Radiograph of the chest May 21, 1937, showed a right middle lobe pneumonia (Figs. 1, 2, and 3), a true central pneumonia. At no time during her entire illness did she appear seriously ill or uncomfortable. Within three weeks from the onset there was complete resolution and resorption of the pneumonic exudate with a complete spontaneous uneventful recovery.

*Case 2.*—A white male, aged nine, was in perfect health until the morning of July 6, 1937, when he awoke with a headache and a temperature of 102°. Otherwise he felt and appeared well. He was not in bed. The obscure temperature continued 102°-103° daily, remitting slightly toward night. Subjective and objective symptoms were practically entirely absent for six days. The parents made very light of the boy's continued fever and no physician was consulted. A profuse perspiration occurred on the seventh day (probably the crisis). A slightly productive cough developed the ninth day—the first symptom referable to the respiratory tract. A physician was called the ninth day, at which time he heard numerous râles in the right apex. X-ray examination of the chest, July 16, 1937 (Fig. 4), the tenth day of illness, showed a resolving right upper lobe pneumonia. At no time during his entire illness did the boy look or feel seriously ill or uncomfortable. The temperature gradually subsided and was normal July 19, 1937. Recovery was spontaneous, complete and uneventful within three weeks from the onset.

### Comment

In both cases the onset was very sudden with no antecedent cold or acute upper respiratory infection. Symptomatically both were silent until the crisis which manifested itself by a profuse perspiration followed by a productive cough. Continued obscure fever was the only sign. Both patients were in a state of comparative well-being throughout their illness. From the roentgen findings both patients should have appeared and felt much sicker. Sputum typing and early serum therapy was impossible. Oxygen therapy was unnecessary. Recovery was complete and uneventful.

### Conclusions

1. Lobar pneumonia is not infrequently latent—particularly in older children.
2. Unexplained or obscure continued fever cases should be investigated for a possible latent pneumonia.

## ROLLER SKATE AMBULATORY TREATMENT OF FRACTURE OF THE PATELLA

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Automobile accidents result in types of fractures that were formerly comparatively rare. Patella fracture especially is becoming more frequent. Many of these are due to the knees of the driver being forcibly thrust against the instrument panel, or the steering rod, or the crank handle of the front window of the car. Back seat passengers frequently fracture the knee cap against the back of the front seat.

Indirect violence usually results in a tearing of the ligaments, causing an initial separation of one inch of the fragments. But the fractures by direct violence, such as occur in automobile accidents, are done when the knee is semi-flexed and the middle portion of the articular surface of the patella rests on the condyles of the femur. As a result the bone fractures at the junction of the middle and lower thirds, and the lower third is often comminuted. However, this crushing type of injury causes no strain upon the ligaments with consequent tearing of the fibrous expansion of the quadriceps and allowing a separation of the fragments. The fascia lata and the intact joint capsule further prevent this separation.

Most of the recent articles on the treatment of these fractures advocate open reduction regardless of the question of sep-

arated fragments. Physicians who use the closed method usually prefer the open reduction, and apologize for not having used it. No appreciable shortening of the period of disability has been noted by those using open reduction. An x-ray examination will reveal separation of the patellar fragments, which can only occur in the presence of severe laceration of the tendon of the quadriceps or the tearing of the lateral portion of the capsule. If no separation is noted and there is no tearing of ligaments, why operate? Since most patellar fractures occurring in automobile accidents are due to direct force and without

separation of the fragments, a conservative method of treatment will give good results, with no danger from an anesthetic nor from operative trauma, and with less expense to the patient.

Satisfactory results are not achieved when bony union is not followed by the full power of extension and flexion. R. Watson Jones relates a case of fracture of the patella in a woman in London 200 years ago who was treated by John Hunter. Hunter says that after prolonged treatment the knee joint presented the dual problem of extension limited by powerlessness and flexion limited by stiffness. Be it noted his problem was not the securing of bony union but a functioning knee joint. While treating the knee-joint instead of the fracture may we not go further and treat the patient as a whole? Ambulant treatment will do much for the patient. Bony union will be facilitated. The general atrophy from disuse of the unaffected parts may be modified, while mobility will add greatly to the patient's morale, and in selected cases the economic factor may be controlled.

The following treatment was given to a comminuted fracture of the left patella due to an automobile collision in which the driver of one car fractured the kneecap against the crank handle of the side window. There was little if any separation of the proximal fragment from the lower fragments. A padded posterior aluminum splint reaching from mid-thigh to the ankle was applied. This was held in place by adhesive strips with especial care given to hold the fragments in close approximation by strips above and below the patella. Two inch roller gauze bandage completed the immobilization. The leg and thigh were elevated for three days; then the patient sat up in bed with the leg extended as desired. Sitting up relaxed the rectus femoris (because it is attached to the pelvis) as much as elevation.

On the sixth day after injury, low heeled oxfords were worn. The set-screw of an ordinary roller skate was removed to disengage the front pair of wheels from the rear pair. The back part of the skate was strapped on the shoe worn on the affected side. The shaft of the skate was held firmly to the foot by means of strap webbing applied in a figure of eight around the ankle and foot. Weight bearing and flexion of the knee were avoided

and relaxation of the quadriceps femoris was obtained when the patient became ambulant on crutches and the roller skate. Every four or five days the splint was removed for



Fig. 1. Roller skate and crutches used in ambulatory treatment of fracture of the patella. Note (a) relaxation of the rectus femoris; (b) immobilization of the knee joint; (c) the absence of weight bearing.

massage and then reapplied. In walking, with each forward surge on the crutches, the splinted leg was trundled ahead on the skate. To lift the leg over an obstacle such as a thick rug the right crutch was used as a lever. Since the adductor muscles are not attached to the patella there was no difficulty in turning by using the sound foot as a pivot and the adductor muscles for circumduction. The patient walked forward down steps, but went up stairs by going backward and dragging the affected leg. The patient, a physician, attended to all office practice and effected several deliveries at the hospital during the period of wearing a skate. Bony union occurred in five weeks as seen by radiograph. At the end of the sixth week the splint was removed and the knee bent over pillows until 45 degree flexion was obtained, then the patient began to walk by the aid of crutches. In three days crutches were discarded for a cane and by the end of the seventh week the cane was



discarded, and the patient drove the car and mounted and descended steps using only the hand rail. All lines of practice were then resumed. At the end of the eighth week all mechanical assistance was discarded. By this time there was full flexion of the leg upon the thigh, but some atrophy of the quadriceps persisted which was rapidly disappearing under the exercise of walking up stairs.

The after-care of patellar fractures following bony union must be intensive and persistent and can best be done by physiological use. R. Watson Jones also says "the most complicated of gymnastic machines and of electric batteries cannot equal the patient's own efforts. During half an hour of physiotherapy a masseuse may stimulate a quadriceps fifty or sixty times. What is that to compare with the constant contraction of postural tone? The valuable time of the masseuse should not be occupied in gently lulling the patient to sleep with soothing massage, but in rigorously goading him into activity, teaching him to regain his own mastery over the inactive muscle, and instructing him in postural and resistance exercises which can be practiced, not for half an hour a day, but for the whole of his ten or fifteen waking hours."

Certain physiological benefits of the skate method of treatment seem obvious. Lateral and rotary movements of the joints effected through adduction and abduction tend to break up early adhesions. Any interposed soft tissue is pulled out by these same movements. The bony parts are stimulated to solid bony repair by the slight friction from movement. These same movements stimulate blood supply and keep up nervous impulses through related group muscles in such a way as to act as trophic aids. The posterior splint allows slight flexion and its small bulk and weight is of aid to the ambulatory patient. The free ankle results in movements of the foot and further improvement of circulation. But greater than any physiological benefits from the use of the roller skate is the almost uninterrupted activity of the patient because of its use.

A word of caution may be given at this point. The free ankle allows for no stiffness at the joint during the immobilization of the knee joint, but the ligaments are weak and early weight bearing resulted in an internal rotation of the ankle, with weakness and swelling of the joint. This was corrected by adhesive plaster strapping with the foot everted, and by the aid of a shoemaker. The shoemaker was requested to split the sole of the shoe on the outer side and insert a long thin wedge of leather. The heel rubber was also lifted and another wedge inserted. The adhesive strapping was discarded in a few days, since the shoe gave sufficient relaxation to the lateral ligaments of the ankle joint and put the medial ligaments on the stretch.

J. Niemach reports early active motion during the first week following fracture, using the physician's hands to keep the fragments from separating. This method would probably add much to the above treatment of fracture of the patella without separation.

This report is submitted in the hope that it may aid in treatment of patellar fractures and possibly be of use in other fractures below the knee. It is a new departure in treatment, but may serve to further increase interest in the ambulatory treatment of various fractures.

### Conclusions

1. The conservative closed treatment in uncomplicated cases of fracture of the patella gives good results with less danger to the patient, and with less expense.
2. Ambulatory treatment on a roller skate is advocated as a method of securing bony union, with less immediate and remote disability. In addition the patient may attend to all or part of his duties.
3. A report of a case treated by the ambulatory skate method is cited wherein the patient was only partially incapacitated for duty and returned to full duty in eight weeks.
4. Physiological use is the best after-treatment of these cases.

## PROLAPSE OF THE UTERUS\*

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J. L. BAER

Prolapse of the uterus exists when this organ descends from its normal level in the pelvis. As long as all parts of the uterus are above the level of the ischial spines there is no prolapse. Elongation of the cervix may carry the external os far below the spines, even to the vestibule. If the parametrial and paravaginal supports hold the corpus uteri at its normal level there is still no prolapse. The tone or slack in these supports is readily determinable on examination. Such examination may be in the recumbent posture with straining or with gentle traction on the cervix, or in the standing posture with straining. There is only slight

play in the vertical axis when the uterus is normally supported.

A precise classification of the degree of prolapse may be stated as follows: first degree, descent of the uterus, the external os reaching below the spines of the ischium; second degree, descent of the uterus, the external os reaching the vaginal atrium; third degree, descent of the uterus, the external os protruding; procidentia, protrusion of the entire organ.

The factors that determine the development of this condition can best be understood by a study of the normal relations of the uterus. At birth this tiny organ lies in the upper pelvis, the fundus pointing vertically. Between birth and puberty something occurs with the result that in 80 per cent of young girls the fundus points toward the symphysis and the corpus is bent almost at right angle to the cervix so that the corpus is now almost horizontal when the individual stands.

In 20 per cent the fundus lies against the sacrum and eventually is found at varying depths behind the cervix and in the sacral hollow.

I believe Sturmdorff has given one important explanation of this variation. The degree of pelvic inclination can determine whether the corpus will normally point anterior or posterior. At birth, symphysis and sacral promontory are on the same horizontal level. When the infant begins to stand and walk the pelvis undergoes a transverse rotation which carries the ilia and sacrum backward and drops the symphysis below the level of the sacral promon-

tory. In the vast majority this "pelvic inclination" approximates 60 degrees. Now the lines of intra-abdominal pressure are deflected by the jutting promontory and iliac fossæ against the back of the corpus uteri, bending it forward against the bladder. Intestinal coils occupy the posterior pelvis and are kept out of the vesico-uterine space.

Lesser degrees of pelvic inclination leave the uterus exposed on both surfaces. Since the posterior trunk is rigid while the abdominal musculature is constantly active, the erect uterus tends to be thrust backward and remain so.

Another explanation of retrodisplacement is the variation in the development of the superior pelvic fascial plane. Foreshortening of the pubo-vesico cervical segment holds the cervix forward, counteracts the effects of pelvic inclination and results in retrodisplacement. When posterior shortening exists, the uterus is found in retrocession. In both these developmental defects the uterus is usually hypoplastic or even infantile.

Since prolapse of the uterus is nearly always associated with and preceded by retrodisplacement it is reasonable to regard primary retrodisplacement as a predisposing factor in prolapse.

Prolapse can occur only when the supporting structures of the uterus give way. Thirty years ago Halban and Tandler demonstrated that these supporting structures are the fascial attachments at the cervico-uterine junction, i.e., the bases of the broad ligaments (cardinal or Mackenrodt ligaments) which insert into the supravaginal cervix and into the upper vaginal wall; the pubo-vesico-cervical fascia; and

\*Read at the Seventy-third Annual Meeting of the Michigan State Medical Society, Detroit, September 21, 1938.



the utero-sacral ligaments. This has been well demonstrated recently by Mengert.

Defective development or injury to these supports will eventually result in descent of the uterus. The state of the pelvic floor and perineal body plays no role in this drama. Innumerable instances of extensive destruction of the lower birth canal, even conversion of vagina and rectum into a cloaca, may be associated with uteri at normal levels. The presence or absence of an enterocele is likewise not a causative factor in prolapse.

The effect of defective development is well shown in the occasional instances of prolapse in the nullipara. The corpus may be forward or backward, the latter being the commoner finding. The presence of a spina bifida demonstrable externally or by Roentgen-ray picture (spina bifida occulta) is a sufficient clue to the basis for the defective development of the supporting fasciæ.

Trauma accounts for nearly all instances of prolapse. The location and extent of the injury determines the degree of prolapse in the first instance and the involvement of adjacent viscera, preëminently the bladder, plays a secondary role. It has long been recognized that retrodisplacement (usually retroversion) is the first clinical evidence in the uterus of birth trauma which may eventuate as a prolapse. With corpus and cervix both pointing in the vaginal axis, intra-abdominal pressure exerts a direct effect on the enfeebled supports.

Women with primary retrodisplacement should show a decidedly higher incidence of subsequent prolapse. A study of enough case histories extending over at least a generation would be necessary to establish or refute this association.

Retrodisplacement carries another threat since broad ligament varicosities and passive congestion of the parous uterus are part of the picture of retrodisplacement. This engorgement adds to the weight of the corpus and further taxes its supports.

Injury to the anterior fascial segment determines the herniation of the bladder. Cystocele is exceedingly common. It may completely obliterate the anterior fornix. Indeed, it may produce marked elongation of the cervix. Yet if the lateral and posterior uterine supports are sound, the corpus

will remain at a normal level. If these supports have yielded, then the cystocele and the retrodisplacement unite to aggravate the prolapse.

TABLE I. AGE INCIDENCE

					1928	1937
					Series	Series
Youngest	22	Oldest	75	Average	45.8	46.2
Under 30					12	12
30-40					55	60
40-50					80	63
50-60					26	46
60-70					33	33
70 and over					6	7

In a ten-year study at Michael Reese Hospital the age incidence of patients with prolapse of the uterus ranged from twenty-two to seventy-five years. The average in our last series was 46.2 years. This is practically the same as in the series previously reported (45.8 years).

TABLE II. PARITY INCIDENCE

Nulliparas	9	Para viii	15
Primiparas	34	Para ix	11
Para ii	87	Para x	8
Para iii	81	Para xi	2
Para iv	72	Para xii	3
Para v	47	Para xiii	1
Para vi	36	Para xiv	2
Para vii	17	Average parity	4.0

In the last 441 patients with prolapse all but nine had borne one or more children. The average number of pregnancies per patient was 3.5+.

TABLE III. STERILIZATION

	1928 Series	1937 Series
Sterilized	46.0%	14.9%
Sterilized previously	1.3%	
Postmenopausal	40.0%	41.1%

Sterilization was performed on 46 per cent of the women in the 1928 series in contrast to an incidence of 14.9 per cent in the 1937 series. This difference obviously was due to the fact that the interposition operation was done so frequently in the first series and was to a large extent replaced by vaginal hysterectomy in the second series.

The 1937 group showed a considerable increase in two of the outstanding symptoms as compared with the previous series; namely, protrusion and bladder distress.

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TABLE IV. SYMPTOMS

	Percentages in	
	1928 Series	1937 Series
Protrusion	58.6	83.7
Discomfort	53.6	46.1
Abdominal pain	18.1	8.1
Backache	28.1	23.1
Bearing down	17.3	14.9
Bladder distress	33.6	40.6
Frequency	30.0	20.8
Dysuria	13.1	10.4
Incontinence	5.4	9.4
Leukorrhea	8.6	14.4
Dysmenorrhea	5.3	1.3
Menorrhagia	7.6	8.5
Metrorrhagia	4.5	9.5

The varying degrees of prolapse and the occurrence of associated pathology is tabulated in Table V. I wish to call particular attention to the increased incidence of enterocele in the second series. Even with the increase the incidence is low (3.1 per cent). I cannot agree, therefore, that the deep cul-de-sac is a predisposing factor in the development of prolapse of the uterus. I feel that the significance of the deep cul-de-sac has been overestimated in the recent literature.

TABLE V. PATHOLOGY

	Percentages in	
	1928 Series	1937 Series
Prolapse		
First degree	11.4	7.8
Second degree	33.2	35.2
Third degree	55.4	57.0
Cystocele and rectocele	73.6	73.7
Rectocele only	9.5	11.8
Enterocele	1.4	3.1
Fibroids	9.0	17.7
Fibrosis uteri	2.7	2.4
Adenomyosis		5.9
Diseased cervix	24.5	30.7
Polyp	1.3	7.2
	1928 Series	1937 Series
Ovarian cyst	5	11
Ovarian fibroid	1	1
Pregnancy		2
Diabetes	6	4
Cardiovascular renal	6	7
Salpingitis	1	1

## Choice of Operation

The primary objective in any operation designed for the cure of prolapse is the permanent achievement of that result. A great variety of procedures has been developed to accomplish this purpose. They may be divided into three general groups: that in which the vagina is sacrificed; that in which the uterus must or may be preserved; and that in which the uterus is sacrificed.

*The Le Fort Group (sacrifice of the vagina):* Vaginal occlusion (colpocleisis),

partial or complete, is the operative procedure adapted to the elderly patient with atrophy of the cervix and with senile atony of the anterior and posterior fascial and muscular structures and in whom marital relations have ceased. This operation, commonly called the Neugebauer or Le Fort operation, has been known for 60 years but has had only a limited popularity until recently. The original procedure is exceedingly simple, is practically 100 per cent curative, and can be done under local infiltration or regional block anesthesia. It involves little or no blood loss or post-operative shock. There are two variations from the original Le Fort colpocleisis: complete excision of the vagina (colpectomy) for those patients in whom there has been a previous total hysterectomy, either abdominal or vaginal, and in whom prolapse of the vagina has occurred as a sequella; and a recent suggestion (Goodall) to make the Le Fort procedure available for elderly women in whom opportunity for marital relations must still be maintained. In this operation the occlusion of the vagina extends downward for one-third to one-half of its length, leaving the distal portion patulous. In two instances this has proved successful in both objectives.

*Conservation of the uterus:* Conservation of the uterus is mandatory in women in the fertile years who look forward to further offspring. I have found parametrial fixation best adapted for this purpose. I formerly employed the Gilliam suspension operation combined with cervical amputation and vaginal reconstruction as indicated. I have discontinued this operation for this purpose because parametrial fixation obviates the necessity for laparotomy and consumes no more time than the vaginal work required in connection with the Gilliam suspension.

This operation properly executed is curative and usually permits of subsequent pregnancy and delivery without recurrence. The operation is simple and has a minimal morbidity.

Conservation of the uterus is elective and, in my opinion, desirable even though fertility is no longer a problem, provided there is no uterine pathology. In such patients prolapse may be cured by the above procedure, parametrial fixation. If the patient is still in the child-bearing years the operation may be combined with sterilization.



The interposition operation has served very well for the cure of prolapse and has given a high percentage of cure. In women of the child-bearing age sterilization is compulsory in this operation. The operation is elected for those patients with a large cystocele, a normal corpus uteri neither too large nor too small, freely movable, and without gross adnexal pathology. Where formerly the interposition operation was done in 42 per cent of all instances of uterine prolapse by the gynecologic staff of the Michael Reese Hospital, its frequency in the last ten years has dwindled to 13.6 per cent.

The first advantage of the interposition operation was supposed to be the cure not only of the prolapse but of very extensive cystocele. The same result can be achieved equally satisfactorily by parametrial fixation plus proper vaginal reconstruction.

*Sacrifice of the uterus:* Vaginal hysterectomy has been strongly advocated for the average instance of prolapse of the uterus where fertility is no longer desired. Its advantages are said to be the removal of an organ which is a potential source of pathology, the possibility of complete access to and an adequate reconstruction of the superior vaginal plane, and the cessation of the recurring menstrual cycle with its accompanying handicaps. Its disadvantages are said to be the loss of the continuity of the structure of the superior plane of the pelvis which should favor adequate repair of the prolapse; a failure following hysterectomy means prolapse of the vagina, which is more difficult to cure than a secondary operation upon the patient in whom cure was attempted with conservation of the uterus; there are women to whom the loss of the menstrual cycle is a psychic shock; the unanswered question of the role of the menstruating uterus in the maintenance of the hormonal balance in the female genitalia; and finally, changes and symptoms in the vagina due to loss of cervical secretion. In my opinion vaginal hysterectomy for the primary cure of prolapse should be limited to those patients in whom the pathology of the uterus itself carries the indication for hysterectomy.

#### Important Principles in the Operations Recommended

*The Le Fort Colpocleisis:* The purpose of this operation is the construction of a broad bridge of adhesion between the posterior and anterior denuded vagina extend-

ing from cervix to atrium, thus locking the uterus above this barrier. Bilateral vaginal tunnels are provided for such secretion as may continue from the cervix. This operation should be limited to elderly women. Therefore prolonged rest in bed is not desirable. However, prolapse in general is frequently accompanied by passive congestion, edema, and ulceration of the exposed surfaces. These conditions should be controlled previous to operation. Local infiltration or regional block anesthesia is desirable. In operations for prolapse in which the uterus is conserved, preliminary curettage should be done. This may be omitted in the Le Fort operation in which one is dealing with an atrophic organ which has been quiescent for many years.

In the classical operation the anterior and posterior vaginal walls are denuded in two parallel strips. The posterior strip extends from the region of the external os to the vaginal-perineal juncture. Anteriorly the denudation should stop not less than 3.0 cm. away from the external urinary meatus. If the anterior denudation is carried too close to the external urinary meatus the subsequent broad approximation of the posterior and anterior denuded vaginal walls results in a tug on the periurethral supports which may lead to urinary incontinence. Complete hemostasis is imperative. At the close of the operation the patency of the bilateral tunnels which extend from the atrium to the cervix should be confirmed. A permanent catheter adds materially to the comfort of the patient and simplifies post-operative care.

A recent modification of this operation (Goodall) is identical in all respects except that the distal one-half to one-third of the vagina is not included and remains available for marital relations.

*Colpectomy:* This operation is indicated for women in whom there has been a previous hysterectomy and in whom there is now a prolapse of the vagina. It can be employed only if marital relations have permanently ceased. The entire vaginal mucosa is dissected away except the usual 3.0 cm. adjacent to the external urinary meatus. Closure must be from within outward and is best carried out by approximation of the lateral walls. This provides for a complete pelvic floor support and adequate support for the prolapsed bladder.

*The Brady operation* is available for the

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TABLE VI. OPERATIVE RESULTS

Operations	1928 Series			1937 Series		
	No.	Deaths	Gross Morbidity Per Cent	No.	Deaths	Gross Morbidity Per Cent
Interposition	91	1	55.1	30	1	40.0
Vaginal hysterectomy	7	1	43.0	116		50.0
Ries fixation	28	1	35.7			
Ventrofixation and plastic	27		44.4	8		12.5
Vaginal plastic	17		11.8	9		33.3
Vaginal occlusion	14		21.7	29	2	3.7
Ventrosuspension	14		57.1	13		7.5
Extravaginal fixation	13		46.0	4		25.0
Supravaginal hysterectomy and plastic	5		60.0	3		33.3
Cervical stump fixation	2					
Panhysterectomy and plastic				3		100.0
Kielland-Wertheim interposition	2	1				
Halban-Porges				6		50.0
Total and average	220	4 (1.8%)	44.5	221	3 (1.3%)	37.7

cure of prolapse of the vagina in patients in whom marital relations must be preserved. This is based on the principle of anchoring the vaginal vault to the anterior abdominal fascia with permanent silk sutures.

*Parametrial fixation:* This operation is devised to restore a uterus reduced to normal size to the normally anteflexed position. The over-all length of the uterus should not exceed 8.0 cm. The posterior placement of the cervix is accomplished by throwing a sling of parametrial tissue from both sides across the anterior surface of the cervix. Reconstruction of the perineal body and pelvic floor aids in the maintenance of the posterior placement of the cervix. The degree of denudation of the anterior vaginal wall is determined by the extent of the accompanying cystocele. Experience has shown that subsequent pregnancy and labor do not usually result in a recurrence of prolapse after a properly executed parametrial fixation. Therefore sterilization is not an essential of this operation. If sterilization is desired, the vesico-uterine reflection must be opened and the uterine tubes occluded by the Walthardt technic (modified Madlener). This involves the crushing of two arms of a loop of uterine tube and ligation in the crushed area with No. 5 waxed silk. This is quick, bloodless, and thus far has not failed in my hands.

*The interposition operation* may be considered as an alternative in lesser degrees of prolapse with marked cystocele and in women past the child-bearing age. The interposition operation was devised to accomplish acute anteflexion of the uterus and utilization of the uterus as a carrier for

the bladder. Here, as in all procedures in which the uterus is conserved, adequate amputation of the cervix is essential. The bladder must be widely dissected free from the cervix and dislodged upward. The vesico-uterine reflection is opened and the fundus uteri is anchored under the symphysis with lateral mattress sutures fixed to the subpubic ligaments.

*Vaginal hysterectomy:* There are various satisfactory methods for vaginal hysterectomy. When this operation is employed for cure of prolapse it is obvious that the structures remaining after the uterus is removed must be so treated as to insure against subsequent vaginal prolapse. The broad ligaments must be approximated in the mid-line and even imbricated when redundant. Both the broad ligaments and the utero-sacral ligaments are available as supports for the vaginal vault. When the utero-sacral ligaments are relatively short it is my preference to secure the posterior vaginal cuff to each ligament separately. When the utero-sacral ligaments are long I prefer to unite them in the mid-line anterior to the rectal tube. The round ligaments are brought together in the mid-line when they are slack, otherwise they are secured to the anterior vaginal vault separately. When possible, anterior and posterior peritoneal edges are brought together, or the anterior peritoneum may be gathered in a purse string which unites the two round ligaments and the posterior peritoneum included similarly with the utero-sacral ligaments. The vaginal vault may be closed vertically or horizontally. I prefer the horizontal closure. I have not found it necessary to use any form of drainage.



TABLE VII. REMOTE RESULTS

Operation	No. Followed	1928 Series			No. Followed	1937 Series		
		Success	Partial	Failure		Success	Partial	Failure
Entire series	121	85.8	6.1	8.1	127	78.7	14.2	7.1
Interposition	64	87.5	4.7	7.8	19	89.2	10.8	
Vaginal hysterectomy	5	100.0			65	70.7	18.4	10.9
Vaginal occlusion	10	100.0			18	94.4		5.6
Ventrosuspension	11	91.0		9.0	6	66.6	33.4	
Ventrofixation	19	94.7		5.3	4	75.0	25.0	
Kocher	12	100.0			4	75.0		25.0

### Operative Results

In Table VI will be found a tabulation of the operative results following various types of operations in the last two series analyzed in the Michael Reese Hospital. There has been a 25 per cent decrease in gross mortality and a somewhat similar decrease in gross morbidity, the latter dropping from 44.5 per cent to 37.7 per cent.

### Remote Results

End-results by personal examination were obtained following the various types of operations in 56.0 per cent of the patients, and the results are listed in Table VII. It should be noted that the highest percentage of failure, 10.9 per cent, was found following vaginal hysterectomy. The percentage of failure for the entire series was 7.1 per cent as contrasted with 8.1 per cent in the 1928 series.

### Palliative Treatment

Among women who suffer from varying degrees of prolapse of the uterus with symptoms there are certain groups who must be relieved without surgery. These include the women who refuse surgery, women whose physical condition makes it unsafe to subject them to any type of operative procedure, and the occasional instance of prolapse associated with early pregnancy. For these patients, relief must be provided by some form of supportive device.

The oldest of the modern devices is the ball pessary, glass or vulcanite, of a size sufficient to prevent its extrusion. This can be used only if the perineal body affords reasonable support and if its use does not interfere too completely with emptying of the rectum. As with all types of pessaries it must be removed at intervals of a month to permit inspection of the vagina for decubitus and ulceration. I have used this very rarely in recent years.

The inflated rubber doughnut is quite satisfactory for first and second degree prolapse. It must be fitted so that it is not too tight, and must be removed monthly, at which time it will be found to have undergone some deflation. It can be refilled with air by using a fine needle and a 5.0 or 10.0 c.c. syringe and kept in use until the rubber surface becomes roughened.

The cup pessary is ideally adapted to the patient who has a third degree prolapse or a procidentia and in whom there is a well preserved cervix and no perineal support. The cup carries the cervix and the length of the stem should be appropriate to the depth at which the cup sits in position. Support is provided by elastic perineal straps fitted to an abdominal belt.

The most recent device which has proved eminently satisfactory for third degree prolapse and procidentia is the Gellhorn vulcanite pessary. This comes in two sizes, is easily adjusted, but requires some perineal structure to maintain it.

### Summary

Definition and classification of prolapse is discussed. The relationship between congenital and acquired retrodisplacement of the uterus and the development of prolapse of the uterus is analyzed. Trauma resulting from childbirth is responsible for nearly all instances of prolapse. Analysis of two five-year studies totaling 441 operations for the cure of prolapse is presented. Choice of operation is considered in three groups: sacrifice of the vagina; sacrifice of the uterus; and conservation of the uterus, either mandatory or elective. Appropriate types of operation under each group are indicated. Important principles in the operations recommended are set forth. Operative results, both immediate and remote, are given. Palliative treatment is discussed for those women who must be relieved without surgery.

# THE INJECTION TREATMENT OF HERNIA

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For over one hundred years the injection treatment has been practiced, but throughout this entire time, until about five years ago, it has been employed for the most part by quacks and irregular practitioners, and I feel very strongly that the exaggerated claims being made for the method by many enthusiasts at the present time is in danger of turning it back to the hands of irregulars and quacks unless a warning is heeded to stop this trend of exaggeration.

In the last five years, a great deal of interest has been shown in this method by many men of unquestioned reputation. They have been immensely impressed with the possibility of cure, and, in many cases, because of their apparent fine results, have become so enthusiastic about it that they have claimed results beyond anything that mature investigation will substantiate. As a result of these claims, many more men are taking up this treatment but they will, undoubtedly, have a very great disappointment if they expect to accomplish anywhere near what is claimed by its enthusiastic proponents.

I have been interested in this subject and made an investigation of it for about five years. I have continuously carried on experimental work for a period of two and one-half years. I have been doing the work clinically for five years and have been doing it quite extensively for about two and one-half years, with a very close follow-up system, and I am convinced that the method has a definite place in surgery.

All of the men writing on this subject have stressed various matters that they consider of importance. None of them has, to any great extent, stressed the point of utmost importance, namely, the selection of cases.

Many claims are made for the cure of 90 to 98 per cent in all hernias. This is absolutely ridiculous, as fully 50 per cent of all hernias are not proper subjects for this treatment under any circumstances. This 50 per cent is made up of the following cases, and, while the percentages mentioned may not be absolutely correct, they are near enough for all practical purposes. The cases that are not to be considered as subjects for this treatment are as follows: Hernia other than inguinal, *i.e.*, umbilical, ventral, femoral, etc., 8 per cent; hernia not entirely reducible, 5 per cent; direct hernia, 17 per cent; large indirect hernia, 10 per

cent; too obese, 10 per cent; making a total of 50 per cent of all hernias which are not proper subjects for the injection treatment.

It is ridiculous to expect any solution or solutions to be capable of building up a wall to fill in the large defects which are so commonly met with in the types of hernia such as the following:

In the direct type of hernia that many are claiming to cure, there is usually a defect one inch or more in diameter. What possible chance is there for a closure of this great defect? Into what tissue can they inject in the region where the direct hernia protrudes in the hopes of closing this defect?

In the femoral region there is nothing but the firmest kind of fascia, no muscles to fibrose or contract. In addition to this, there is a very definite danger of injecting into the femoral vein. In recurrent hernia, adhesions are numerous and impossible to locate. The intestine is almost invariably adherent in the defect. In umbilical hernia, the hernial ring is entirely firm fibrous tissue and its contraction or narrowing by injection seems to be practically out of the question. In the large indirect hernias, the defect is too great to hope for cure. In the very obese patient, one cannot be sure enough of exactly where the injection is going to make it a safe procedure. In the hernias that are not entirely reducible, all are agreed that it is too dangerous to attempt injection.

This leaves, then, 50 per cent of hernias which, we believe, are proper subjects for the injection treatment and this group is composed entirely of *small indirect* hernias on moderately thin individuals. Now, I do not claim that *none* of the hernias in the aforementioned group can be cured, but so very small a percentage can be cured



that it is certainly not worth while to subject them to the treatment.

The rationale of this treatment is clear. Many people have attained the age of forty to fifty and then developed a hernia and on operation it was found that the patient had a definite congenital sac. In other words, the fifty-year-old patient carried the sac for forty-nine years without having a hernia. Then, at the age of fifty years, he suddenly shows up with an indirect inguinal hernia. It is interesting to contemplate just what happened that he should develop a hernia at this time. The only thing that could have happened to him was a gradual relaxation of red muscle fibers of the internal oblique and transversalis at the internal ring surrounding the cord and the neck of the sac, this relaxation getting to such a stage that it allows a protrusion of some of the abdominal contents into this already preformed sac. Now, it does not require that some great catastrophe take place in this region. It usually means only that a very slight change in this fifty-year-old man has taken place and a very slight difference between the condition at forty-nine and at fifty, but at forty-nine he did not have a hernia and at fifty he has one. While a *slight* thing occurred to him in this very definite region then a very *slight* thing needs to be done to put this man back into the condition he was at forty-nine, when he had no hernia. The only reasonable way to view the subject of the injection treatment at all or entertain it for a moment, is to view it from this standpoint.

It seems reasonable that we should be able to inject into these muscle fibers some agent which will cause some fibrous tissue formation and some resulting constriction in them which will take them up enough to prevent anything dropping into this sac. Both our clinical experience and our experimental work seem to bear out this contention.

Most of the men who have written on this subject have stated just where the first ring was to be found. They have generally located the internal ring one centimeter above the half-way distance from the spine of the pubis to the anterior superior spine of the ilium. These writers have invariably said that in making the injection one should invaginate the scrotum through the external ring and palpate the internal ring. It is absolutely im-

possible to invaginate the scrotum through the external ring sufficiently to palpate the internal ring, if the internal ring is where these writers say it is or where it is normally found. It is at times possible to palpate the internal ring through the external ring but this is always in the case where the internal ring has been moved down much closer than normal to the external ring. This is in the large hernia of long duration where repeated coughing and repeated straining has pushed it from its normal location. It has been repeatedly stated that after injecting around the internal ring one should put a number of injections down the inguinal canal. This again is entirely uncalled for and of no value. It must be borne in mind that an indirect hernia is in itself not due to a defect in the hernial canal. It is not primarily evidence of weakness or defect in the inguinal region excepting at the internal ring. The fact that a man has an indirect hernia is absolutely no evidence that he is in danger because of any weakness throughout the extent of his inguinal canal. This is an entirely different condition from that found in a direct hernia, in which case, as pointed out above, we would not consider the use of this method.

There is no more reason for making "prophylactic" injections in the inguinal canal than there would be for operating on a patient as a preventative for fear of his getting a hernia. Many writers on this subject have stressed the point that if a hernia returns after it has been injected we should not consider it a *recurrence* but rather insufficient treatment. It would be just as fair to say, after a recurrence following an operation, that a man has not had a recurrence but has had an insufficient operation.

Now that we have disposed of 50 per cent of hernias which are not proper subjects for this treatment we should take up the matter of dealing with the remaining 50 per cent. As mentioned, these constitute only small indirect hernias on thin individuals. What percentage of these hernias can we cure? It is reasonable to assume that we can cure 25 per cent of these subjects or, in other words, 12.5 per cent of all hernias. This is a tremendous difference from the 90 to 98 per cent cures claimed by many writers, but I am equally sure that this claim can be substan-

tiated by many men after a careful selection of patients and a meticulous technic in their treatment. I believe that in stating this I am a better friend of the injection treatment of hernia than many who are making extravagant claims for it, which claims cannot be substantiated over a long period of time. Unfortunately for us, while "Time heals many wounds," it does not heal *any* hernia. It (time) is the only element, however, by which we can judge results in this treatment as well as in the operative treatment.

Innumerable times I have treated cases and eliminated any sign of a hernia only to have the patient present himself a few months after he has removed the truss with the hernia the same or similar to that which he had when he started the treatment. On the other hand, quite a number of cases of hernia have not recurred. *Time*, and a lot of it, is the only thing that will tell us how near right our percentage estimate is going to be. We have full statistics on the cases treated to date but a partial list of our results may suffice for the time. We do not start to figure time until after the truss is removed. The following cases, however, are to all appearances cured: Two cases with truss off eighteen months; two with truss off fifteen months; six with truss off one year; 12 with truss off nine months to one year, and many more cases for a less period of time.

We do not, at present, have enough confidence in the injection treatment to promise a cure nor to charge for our injections *per se*. The patient is told what his chance of cure is and an arrangement is made on the basis that if the injections fail to cure him he will still be operated upon without an additional fee. When a sufficient number of injections has been given, and the man removes his truss and finds after a time that his hernia has returned, he is advised to have an operation. He is further reminded that his operation is all paid for. However, it has been our invariable experience that these men, even under these circumstances, have decided to take more treatment rather than be operated on, as they are still hopeful that they may be thus cured.

Our experimental work has been carried out, as mentioned, continuously for two and one-half years. In the first experiment, injections of the various available propie-

tary solutions were made. Sections were made from these tissues at ten-day intervals. The early sections all showed a beautiful condition of fibrosis and we were very enthusiastic. However, as the later sections were taken at forty and fifty days and up to one hundred days, the fibrotic tissue rapidly disappeared until there was nothing left. We were then reminded that this did not compare with the clinical application since we had given only one injection in each area in the experimental work. We, therefore, on the next series, made five injections in the one area, repeating our method of taking sections at about ten-day intervals. At the end of a similar number of days, we found a condition very similar to the first experiment. Several other series of experiments were tried with much the same results and some had to be eliminated on account of technical errors. Our last experiment (which was carried out under a very careful control system, in which two separate dogs were used for each date for each solution) showed an extensive amount of fibrotic tissue in the early sections but a gradually diminishing amount in the later ones up to the last, which were taken eighty days after last injection, and, while these contain some definite evidence of fibrosis, it is much less than the early ones had.

I feel that the very great enthusiasm of many of the proponents of this method was due to the fact that their results were estimated at too early a date after the treatment had been administered, as note Coley's analysis of Harris' and White's report:

"The analysis of series published by Harris and White, however, reveals the fact that in thirty-three out of one hundred cases the treatment had not been completed. Moreover, out of the remaining sixty-seven, thirty-nine had been observed less than three months after removal of their truss; fifty-six for less than five months; and only eleven had been followed for a period of six months or more."

Burdick and Coley reported ninety-two cases treated with 3.44 per cent cures.

If Burdick and Coley had selected their cases on the basis recommended in this article and had eliminated all cases *not* subjects for this treatment, their results on the remaining would have proved very similar to ours.

### Summary

1. There is a very definite value to the injection treatment, which has been greatly exaggerated by many enthusiasts.
2. The selection of cases, according to



the plan outlined here, is of the utmost importance.

3. The percentage of cure will be somewhere between 12 and 17 per cent of all hernias, which means 25 to 35 per cent of cases accepted for treatment.

4. Conditions under which this treatment has been carried on by quacks and irregulars for over one hundred years will again obtain unless a warning is issued against

extravagant and unwarranted claims of cures.

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## THE EDUCATIONAL VALUE OF OUR STUDENT HEALTH SERVICES

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The economic difficulties of the past few years have led to an apparent demand on the part of the public for an increased participation by the government in medical services. Whether authentic or not, this demand has caused considerable concern to the medical profession. The practicing physicians of this country are convinced that the public can best be served by maintaining the individual physician as a free agent to deal with his patients unhampered by excessive regulation or regimentation.

It is not the purpose of this paper to debate the desirability or the defects of various schemes that have been suggested, or that may be suggested, for the socialization of medical practice. Rather it is hoped merely to point out a method of approach to the problem that up to the present time has received too little attention from the physicians of the country.

It has been often stated that the students in our colleges and universities today will be our cultural, political and industrial leaders tomorrow. One of the functions of our institutions of higher learning is to train these students in straight thinking, to distinguish between fact and propaganda. If we can present to these future leaders the problems of medical practice as they apply to personal and public health, and can teach them to expect only the best of medical service from practicing physicians of the country, we shall have less to fear from the future citizens of the nation in the form of demands for unworkable and inefficient medical practice schemes.

Student Health Services will be found in practically all of the colleges and universities of the country. The students during the college years will come in contact with this department of their school more or

less frequently, and through the activities of the student health service will be taught what good medical attention is, what the medical profession has to offer them in the form of positive health aids, what constitutes intelligent preventive medicine, and what the practicing physician can do for them and their family after graduation. If the thousands of college graduates being turned out each year leave school with this understanding of medicine and the medical profession, certainly a great step has been taken in preventing the development of foolish health schemes.

Perhaps a brief outline of the development of the student health services in our colleges, with particular reference to the work done at Wayne University in Detroit, will help to make clearer the opportunities here outlined.

It has long been an established and accepted fact that colleges and universities should assume some responsibility for the physical life and health of their students. Since the beginning of the first student health service at Amherst in 1860 for the purpose of selecting students physically ca-

pable of engaging in athletics and sports, the scope of the service rendered by student health services to the student and to the school has gradually increased.

The amount of responsibility assumed varies greatly with the size of the college, its location, and underlying philosophy of its health obligation to the student. The older, larger, and privately endowed schools have, for the most part, developed student health services which provide essentially a complete medical and surgical service to the student for the payment of an annual fee.

This broad interpretation of a college's obligation to the student is, of course, a form of health insurance; for, by the payment of an annual fee, the student is usually given complete medical and surgical care, dental service, x-ray and laboratory service, and a varying length of hospitalization if necessary.

The objectives of a student health service in any college may be briefly outlined as follows:

1. Sufficient education and training of the student to enable him to care for his health intelligently, through hygienic and proper habits of living. The hygiene of the student in college today will, in a sense, become the hygiene of the population in which he will be a leader in the future.

The college health problem is not so much concerned with disease as with the fostering and increasing the strength of people not yet mature, so that a foundation may be laid for long, healthy lives.

2. Protection of the student body as a group from the introduction and spread of contagious and communicable diseases.

3. Supervision of the sanitary facilities of the school buildings, dormitories, rooming houses, etc., that the student may not be forced to live or work in unhygienic surroundings.

4. Care of acute illnesses which require immediate and emergency attention.

5. Physical examinations of all entering students to determine their fitness to participate in the required courses of physical education and in the more strenuous elective intercollegiate athletics. To do this, adequate records must be kept of all students, and competent interpretation made of the results of the examination.

6. Assistance to the student in selecting or planning his course of study so that it will correlate with his physical and mental

abilities. The prevention of overwork on the part of some students is often a necessity. Inasmuch as the student seldom pays by his tuition the actual cost of his education to the school, this phase of the student health service work may be interpreted as a safeguard of the capital investment of the institution. There is no economy in graduating a student who will be shortly compelled to withdraw from the practice of his profession because of illness, due to poor supervision of his health habits while attending college.

Fundamentally, the problems of the student health service in Wayne University are the same as in any school of higher education. The students are of the same age group and are no better nor any less prepared for college life than students of other schools; therefore, aspects of the health education of this group are essentially the same in all schools.

There is, however, less need for the broad administrative development of the health service in the municipal school that is found in the larger, endowed school. Most of the students in a municipal university live at home. If there are dormitories on the campus, they will be few and small, and will house relatively few students. Many of the city colleges have no dormitories; the few students attending the school from out of town find their own accommodations. When the school district is located in a city, these rooming houses will be supervised by the local department of health and should, therefore, constitute no health problem to the university.

The fact that most students in a municipal university live at home makes the handling of their health a different problem than in the ordinary school. Students who have traveled long distances away from home to attend college have a right to expect that facilities will be provided for their care in the event of illness. The university must stand, in a sense, in place of the parents in caring for the student; and this is a generally accepted theory in most universities. Moreover, in the case of large schools located in small towns or cities, local medical facilities are often inadequate to care for the large numbers of students brought to the community by the school. The authorities are, therefore, of necessity forced to provide satisfactory medical service.



When, however, the majority of students live at home or with relatives, this responsibility can and should remain at home. There will, in most cases, be a family physician who has better knowledge of the personal and family history than the student health service physician could hope to have with his brief contacts. There is no logical reason why the family physician should not continue to care for such a student in the same manner he would have had not the student enrolled in the university.

The same thing may be said of hospitalization of a student. The municipal university is not faced with that problem as are other schools because the parents or relatives of the student are at hand and can see that adequate hospital care is given if needed.

The few cases of out-of-town students in the city university who require hospitalization can be cared for in emergency by sending them to the city hospital. The school is, in this way, saved the expense of erecting and maintaining an infirmary for ill students. This will perhaps make the health service less adequate in caring for the students than it might be; but, in general, local facilities will be sufficient to care for the few cases where the school must assume some degree of emergency responsibility.

Wayne University is a municipal university operated by the Board of Education of the City of Detroit. It was formed by the union, in 1934, of five colleges operated by the Board in order to facilitate the administration of the various schools.

The Student Health Service was first organized in 1928 as a part of the College of Arts and Sciences. A physician was employed on a part-time basis with a registered nurse in attendance at all times. Physical examinations were made of entering students, and an office and clinic maintained for emergency care and consultation.

In 1935, a full-time physician and member of the staff of the College of Medicine was made director of the Health Service in order to bring the various medical activities of the Board of Education under the direction of the College of Medicine. The Health Service is now located in its own building at 5041 Cass Avenue, just north of the main building of the University. Thorough physical examinations are made of all entering students and their records

are kept up to date during their college careers.

Students are graded in accordance with the results of their physical examinations and permission is given or withheld for participation in athletic activities. All college sports are supervised by the Health Service, and a physician is in attendance at all football games.

Since its inception, the Student Health Service has become of increasing value to the students of the University. Requests for service have increased from an average of a few hundred per year during the first several years to a total of 6,468 in 1936-1937. The reasons for these requests vary from routine rechecks of physical findings to a need for care in sudden acute illness. There is no follow-up system in routine use at the present time, but it is needed, and will be started as soon as possible. All physical defects found during the examinations and needing correction are referred to the parents and the family doctor for appropriate care.

The students of Wayne University are not given medical care within the usual meaning of that term. Emergency care is given, but subsequent treatment, if necessary, is referred to the family physician. Many students consult the Health Service regarding chronic illness or ask advice about treatment of a known defect. Such advice and consultations are freely given, but all treatments and actual care of the student is placed in the hands of the parents or guardian and family doctor.

Athletes competing or trying out for teams representing the University are given medical care in the event of injury to the extent of the facilities of the Health Service. When such facilities are inadequate, the student is referred to the family physician or an appropriate specialist. In circumstances where it is deemed advisable, the physician's fee is paid by the University.

No hospitalization is offered to the students by the Health Service, and no infirmary is maintained. Wayne University's Health Service fee of \$1.50 a semester is the lowest in the United States for a university of comparable size maintaining a regular student health service with a full-time physician, and where such a fee is charged. A few beds are kept in readiness in the Health Service Building for emer-

gency illness, but the student is kept there only until arrangements are made for his removal to the home, or hospital, if necessary. These beds are also available to students assigned to regular rest periods during the day by the Health Service because of chronic ill health.

Education of the students in matters of health and hygiene is considered the main objective of the Student Health Service of Wayne University. An attempt is made during each personal interview to give authentic advice regarding personal health problems to the end that the student may better understand what can be done and where such aid may be obtained. During the past year, 2,080 students were referred to their own doctors or dentists for appropriate care; and when the student had no family physician, aid was given in selecting one appropriate to the need from a list approved by the Wayne County Medical Society. We feel that the practicing physicians of Wayne County are our partners in the conduct of the Health Service.

It is felt that the student completes his four years in college with a better understanding of what medical science has to offer, and a knowledge of how to utilize that information for his own benefit. He should, by that time, be on good terms with his family doctor; we feel that every such contact made should be to the benefit of medical science, the physician, and the patient.

#### Summary

1. Student Health Service departments are present in practically all of the nation's

colleges and universities to give various degrees of medical care and authentic advice to students in health matters.

2. Proper education and training of these students in such matters will greatly aid in discouraging the demand by the public for unworkable and inefficient medical practice schemes.

3. The coöperation of the medical profession with the colleges is desirable in attaining this objective. The practicing physicians of Wayne County, Michigan, are in effect partners in the Student Health Service at Wayne University.

4. The municipal university is not under the obligation of providing the same extensive medical care for the student as is the larger, older, privately endowed school, where a majority of students are living away from home.

5. The main objective of the student health service in any university should be the education of the student regarding matters of personal health and hygiene, and the strengthening of the bond between the student and his private physician when medical care is needed.

6. The usual municipal university will find the city hospital facilities adequate for the care of ill students, and need not maintain any student infirmary.

7. Physical examinations upon entrance, supervision of athletics, control of contagious diseases, and inspection of the sanitary facilities of the school buildings should be a part of the student health service program in a municipal university as in any other college or university.

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## INFLUENCE OF DISEASE ON HISTORY\*

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To Dr. Samuel Johnson, history was a narration of events and facts delivered with dignity. But certainly our generation smiles at the dignity and questions the facts as told by the historians of the past. We seek further and ask to know the reason for the facts they so glibly relate. What are the reasons for the passing of the "Glory of Greece" and the "Grandeur of Rome," for the failure of Spanish supremacy and the ascendancy of England in Elizabeth's time?

History is voluminous in the details concerning the strife of man against man, or man against the elements, and rarely mentions the all-important account of man's fight against disease. Certainly, if history

is a true record of man's adjustment to environment and his gradual conquest or control of nature, along with his mistakes and

\*Read before The Detroit Medical History Society, January 27, 1937.



corrections of these mistakes, and in general an account of his pursuit of life, liberty and happiness, his long-time conflict with endemic or epidemic disease particularly should be included.

This shortcoming can likely be traced to the early belief of man. Being ignorant of the nature of disease and its causes, he regarded it as an affliction sent on him by blind fate, or as open acts of an angered God to give him a deserved punishment for his sins. Thus, the early writers felt little need to ask why they fell, and failed to record them faithfully.

Since the causes of disease have become among the things known and understood, the recordings of their incidence has found their place in recent pages of history. But, previous to the scientific awakening of the nineteenth century, one warrior soldier in his armoured suit, or one trifling war with a few thousand men pitted against a few other men at close range, was more important to the writers of history than were the myriads of peaceful farmers, bakers or tradesmen who carried on their peace time occupations, lived as decent folk and carried on for posterity. Even today, the daily press is inclined to rake the five continents for murders, banditry, thefts and sensational adulteries, rather than to fill their pages with daily work-a-day habits of the people whom they serve. Violence and fury is history, but it is not the whole of history and only in the twentieth century has man begun to realize this fact.

Thus disease and the gradual control of disease are tremendous moulders of history. Sir Thomas Browne aptly said that "the world is not an inn, but a hospital." Early writers chronicle the smallest of wars but scarcely mention the great plagues and epidemics which turned the events of history, many times without deference to any man or nation of men.

We may assume that pre-historic man struggled with visible forces, such as wild beasts, ape-men, jungles, floods and famine mainly, but that disease played an important rôle, also, is evidenced by findings in the disease-racked mummies uncovered in Egypt.

That nomadic man contended with disease, too, is proven by looking at our own Western World Indians. When living here today and away tomorrow, they remained

strong and burly. But after being touched by the white man and grouping themselves in larger and more permanent places and somewhat broken to community ways, they polluted their waters and the soil they trod upon, and diseases set in which were unknown before. The gradual extinction of the Redskin has been brought about by diseases of civilization, not by the brutality or sword of the white man.

That these primitive races instinctively realized their sense of security was in their isolated existence, there is much evidence in their customs. One Borneo tribe fumigates any stranger coming into their midst by singeing the wanderer with burning bark. Some Javanese anoint the stranger and his boats with green leaves. A Bechuana tribesman gone longer than a week from his tribe must shave his body from crown to toe before returning in order to rid himself of the evil he may have contracted from the strangers with whom he has mingled. Indeed the envoys of the Emperor Justinian had to pass between two purifying fires before delivering their messages to the Turks.

Enough of generalities, so on to more dramatic episodes as promulgated by some of the great epidemics of time. The Talmud and the Bible both refer to the pestilence called down on the people by God himself, in the one instance on the Pharaohs to release the Chosen People from their yoke, and the other, not long after, a plague on the Chosen People themselves for their indulgences, which wiped out more than thirty thousand followers of Moses, even before they reached the "Promised Land." The effect of these epidemics or the diseases which caused them is not clear, and they are merely mentioned as early harbingers of what to expect later.

The first great scourge of which we have definite record is that known as the Black Death of Athens in 430 B. C. Its origin is rather obscure but it was probably introduced from Ethiopia and Egypt. Pericles, the Wise, ruled Athens in all her glory, and had just begun the war with Sparta. Because the first year's skirmishes had been in favor of Sparta, all the countryside inhabitants of Attica had sought refuge inside Athens' wall. This overcrowding without regard for salubrity formed a rich soil indeed. The pestilence first appeared

at Piræus, the seaport of Athens, and struck Athens soon after with a deadly blow indeed. One-half of the twelve hundred rich citizens of Athens died immediately and more than half of the heavy-laden soldier defenders succumbed in the first weeks of the disease. Despair overcame these crowded people and their high moral conduct went to pieces, and the populace indulged in all sorts of licentiousness, murder, rape and rapine. The laws and the Gods had deserted them and the sayings of the oracle were fulfilled:

"Two heavy judgments will at once befall,  
A Doric war without, a plague within your wall."

Pericles, the great builder of Athens, became unpopular because he had started the war which the people believed had been the cause of their misery. But he sent out an army against the Spartans, which failed, because the plague destroyed far more than did the enemy. The fleet sent out suffered the same fate and at last Pericles himself succumbed. With his death died the Golden Age of Greece and after about two years more of the Plague, the population of Athens was reduced by one-third. What is probably more important, her genii succumbed without leaving any successors.

For the medical picture of this scourge we must rely on the eye witness Thucydides. He comments on the great thirst of the sufferers and reddish spots on their bodies. Swollen glands with a greenish discharge were referred to, so that we now know undoubtedly this disease which caused the end of the Golden Age was bubonic plague. Athens fell, not because of the qualities of the Spartan soldiers or their courage, but solely because of the ravages of the bubonic plague, which as we shall see has turned the course of history more effectively than all the armed forces which have ever carried the weapons of war on all the seas and lands of the world. From this time on the civilized world has not been free from *Bacillus Pestis* infection. Following the Athens plague, it persisted in all parts of the world and as was the custom in those days the people prayed to a saint for deliverance from its ravages. Thus were Churches built; notable among them are the Church of San Rocco in Venice and Saint Sebastian in Rome, the latter dedicated to the Saint familiar to us in art as the martyr soldier shot with arrows. The plague

coerced the Roman Emperors throughout their several reigns, sometimes aiding their causes, but in general breaking down the master minds of the greatest state this earth has ever known. After Pompeii it was said ten thousand died daily, and while the disease stayed the ravages of Attila from the north in 400 A. D., it made possible the victory in Italy of the Lombards in the seventh century and the final breakdown of the Empire.

These instances were meager, though, when compared to the epidemic of the pneumonic form of bubonic plague known as "The Black Death" which swept the entire known world and decimated its population. This epidemic started in Asia and was said to have killed at least thirteen million Occidentals. Because of this disease, men failed to bank their treacherous rivers, and flood and famine followed into China with fatality of even greater numbers. Gradually working westward, it was rapidly dispersed by soldiers of Genoa, returning from the war in the Crimea, and, aided by the traffic from that free port Genoa, it reached England in 1348. In one year's time so great and so rapid was the fatality that the population of the world was cut in half. Pope Clement the Sixth stated that forty-two million perished. The river Rhone was consecrated in France by the Pope to make it possible to bury the devout, for it was impossible to find ground enough to bury the dead. London alone lost one hundred thousand, but greater tragedy was to visit this capital in 1665, the year of London's great plague.

Such a convulsion of humanity necessarily was more than stupendous in changing the course of history. Let us look at some of the trends which humankind took, with particular attention to England, for in this country we have more accurate knowledge of the conditions than in some of the other nations. Morally it seemed to be contradictory, because while it would be natural to assume a more reverent attitude toward life, on the part of the survivors, exactly the opposite took place. The authority and influence of laws, human and divine, vanished as though they had never existed. Traditions of the ages were disregarded, just as they had been before in Athens, and as they were manifested after the World War upheaval of 1914. Licentiousness and debauchery sprang up as appa-



rent effects of having seen the pious and the wealthy stricken by the plague; this was too much for them to endure. Life became valueless in the minds of the survivors and was considered just as temporary as the night was long. Throughout Europe it completely broke the feudal system, bonds were broken that never should have existed, and it made possible the rise of the common man, giving him a voice in the nation's affairs which he never had before. Art, trade, and industry were paralyzed, particularly agriculture, and served to lure men from the soil by promoting urban growth and actually preparing the way for the coming industrial revolution. It broke the power of the church, and, although historians do not state it, the plague definitely made Luther possible and the Reformation a fact. This took place because the old guards of the Church died in such number it was necessary to replace them with younger men, more poorly equipped in moral abstinences and scholarships, and each with less regard for the authority of the Pope. These lesser vicars soon brought about the flourishing of the Flagellants, made up of a group of faithful ignorant people banded together and dressed meagerly with a red cross on their shirts. Going from town to village they would be welcomed by the ringing of the church bells and received with deep respect. Proceeding to the church and exhorting the people to repent, they would begin their rite of flagellation. This rite consisted in thrashing the victims with a hooked leash and finally saying, "God grants your pardon for your sins—stand up." Thus the terror-stricken and pestilence-ridden populace were fertile soil for the spread of this motley group, especially when they claimed divine origin. As these bands grew in size and all western Europe was overrun with pilgrimages, this was another means of continuing the spread of the plague. As their power grew, they gradually assumed more claims and started healing the sick, demolishing the clergy and taking full charge of the churches, hereby questioning the ancient hierarchy of the church itself. Only because the Wise Pope Clement the Sixth, at Avignon, showed judgment in prohibiting, on pain of excommunication, anyone from taking part in the pilgrimages, did he save the weakening power of the church.

With the population halved and the Serfs

freed by death of their manorial lords, the ubiquitous law of supply and demand brought about an increase in wages for their labors, increasing their incomes more than four-fold. In order to attempt to control this the feudal lords passed laws prohibiting the laborers freedom of movement from one parish to another. This brought about a banding together of those workers in one trade, for the first instance of collective bargaining. Thus the forerunner of the clash between Capital and Labor was brought about by no less an episode than a disease, "The Black Death."

Because of these higher wages and the unprofitableness of the large tracts by the manorial lords, these very manors were subleased or sold into smaller divisions. Thus land was distributed to a greater number of men and a more equal division of the world's goods was brought about. As a result, the common man found himself economically better situated. Land was plentiful and therefore rents low, because there were fewer to inhabit the land, and the wages were higher for the same reason. Thus with the misery and desolation came elbow room and a more even distribution of material things. The standard of living was raised and since no property had been destroyed each survivor had the share of two. The pressure of population had been relieved and men had more leisure time to develop the arts, and for the pursuit of happiness. Some writers lay the Birth of the Renaissance at the door of the "Black Death." While the plague influenced history stupendously, it is by no means the only disease that has changed the course of events of history's onward march.

Smallpox has contributed much in the course of world affairs, involving that of the western hemisphere and our own country to a great extent. The origin of smallpox is obscure, but we know certainly that it existed long before man kept a record even of his war conquests. Like the plague, it was probably prevalent in China and the Orient long before it was known in the western world. The first recorded visitation of it as an epidemic is that in Rome in the second century, when it was brought back from a successful repulsion of Assyria by Marcus Aurelius. The description of the epidemic closely follows that of the Athenian plague, in that thousands were buried or burned daily. The Romans resorted to lus-



tration, and, as usual, feasted and prayed to their Gods for deliverance. Because the outlying districts of the Empire were revolting and because armies were sent from the central city to subjugate the rebels, the disease spread rapidly over the entire Empire, from Persia on the east to the Rhine on the west. For fifteen years it went unabated and raged unmercifully. Eventually, the greatest of Roman Emperors, Marcus Aurelius, succumbed, just as did Pericles. The disease from this time on was, at least, endemic and many writers date the undermining of the Roman Empire from the persistent ravages of this one disease. The decline assuredly set in with the death of Marcus Aurelius, the wise Emperor. During the next twelve centuries, the disease was present in more or less epidemic proportions as we would consider it today. In England, as late as 1776, a want ad in a London paper lists the following: "Wanted—A man of twenty or thirty years old for footman and butler—he must be of Anglican faith and have had smallpox"; showing that it was the fear of society to have the disease break out in their servants' quarters because it spread so rapidly. During the Elizabethan period it is said one out of ten succumbed to the disease and one out of five of the survivors had scars caused by the pox. The disease reached all corners of the earth eventually, first appearing in Japan in 900 A. D., Siberia in 1600, Australia not until 1838, and the first case in Hawaii was in 1853.

The western hemisphere became infected epidemically fifteen years after Columbus' memorable exploration voyage, and because of its ravages the white man was enabled to successfully colonize the Americans and overcome the Indians. Whole tribes on the islands of the West Indies were demolished by the epidemic and on being carried to Mexico over three million natives were killed. This alone explains why the few Spanish conquistadores were able to control the destinies of the southern third of North America for so long a time.

The Spaniards were not the only ones aided by this pestilence, for as early as 1649 in Boston, our Puritan forebears, even though they feared the pox themselves, saw in it a direct intervention of the Lord in their behalf as they realized the disease destroyed far more Indians than colonists. The Reverend Amos Adams definitely admitted

that the smallpox was a blessing of the Lord, in that the savages would have been too strong to conquer had not smallpox killed so many of them. Thus we must concede that the very foundation of our country was in no small way attributed to the existence of smallpox in an epidemic form. Had the great Edward Jenner preceded the colonization of America, and received the support of the great Lady Mary Montague, Louis the Sixteenth and the English Royal family, who can tell what changes would have taken place in the development of the New World?

Another disease disseminated in the early days of history and now seldom seen among civilized people, but which definitely altered history, is that of leprosy. Its origin is more ancient than that of smallpox or the plague. Our earliest references to it were made in the Papyrus Ebers dating back as far as 1200 B. C. Apparently it came to light in Egypt, being carried by the Israelites from Palestine, from whence the wandering Jew carried it to the entire world, assisted, of course, by the conquering Roman soldiers. Then, with break-up of this greatest of empires, the boundaries of the disease became limitless. Because of its prevalence in the middle ages, segregation houses of Lazarus were established in all sections of the world by the church. The origin of the watering spa is directly traceable to the disease, our legends tell us. Britain's king Bladud in 900 B. C. was cured by bathing in a muddy pool following the example of diseased swine. Returning to his court cured, he set about to erect a shrine on the site of this miraculous mud hole. This was the founding of Bath, England, which today is still England's greatest health resort. Leprosy reached its peak incidence in Europe during the years when the Roman Church was supreme and with the outbreak of the Reformation it relatively disappeared. In western Europe, during the thirteenth century, there were over nineteen thousand Lazar houses. Just why this is a fact may never be explained, but it did bring forth the theory of it being caused by the eating of fish as expounded by Jonathan Hutchinson, the most versatile of English physicians. The fact that during its height leprosy was unknown in Greek Orthodox Russia and that it prevailed particularly in Norway and Sweden, whose people lived from the sea, and was most persistent



along the sea coast among sea-abiding men, made his ingenious theory at least reasonable.

Because leprosy, like typhus and the plague, was a disease of the poor and associated with filth, it did not strike down bishops, kings, nobles and warriors. Since it was less contagious than the plague, its influence on history has not been so resounding. An occasional exception, of course, is notable when we recall that Robert Bruce, the Liberator of Scotland, was a leper and died of the disease. Had he lived longer maybe there never would have been a United Kingdom.

While it did not slay armies or destroy whole communities, it has insidiously brought tragedy and despair into millions of lives, slowly destroying them and never sparing any of its victims.

The influence of Father Damien, the ministering saint or priest, to the afflicted and his work among them even in Honolulu and Molokai, established the efficacy of quarantine. Recently, the cure of this disease with Chaulmoogra oils is all too well known to relate. It goes more with the conquest of disease than with a tale on how it has influenced history. The story of its discovery, though, is most interesting. Legend relates that a powerful potentate in India was afflicted with leprosy and voluntarily banished himself to the jungle, living as best he could on the herbs and leaves the jungle offered. Among these were the dead leaves of the kakaw tree. After a few months of this voluntary exile, he discovered himself to be cured and he then returned to his throne and married his princess. Through his influence, then, the natives of India discovered this curative effect of the kakaw seeds and the oil pressed from them. This now is recognized to be practically a specific for the bacillus of Hansen.

More dramatic than leprosy, by far, is that role played by malaria and which still seems to be one of the major diseases yet to be controlled, in order to bridle its ill effects on human kind and lessen its historical significance. The fall of Greece, of Rome and the failure of all tropical races can be definitely laid at the door of malaria. Circle the earth at the equator with an area six thousand miles wide and you include half the land and its most fertile land too, as well as half the people of the earth. In

this region were the founders of civilization and the beginnings of intellectual attainment. But these people in this region have lost their dominance for one reason and one reason only—namely, malaria. Even today it is said one-third of all tropical dwellers suffer from malaria.

While the Golden Age of Athens, as we have seen, ended with the plague which after destroying passed on, malaria spread and continued the deterioration of Greece. It was introduced to the flowering peninsula from Egypt about 500 B. C. and has remained an inhabitant ever since. The marvel is, that modern Greece still exists as a nation after two thousand years of chills and fevers and enlarged spleens. That Greece fared better than Rome is evident, in that Rome, as a nation, ceased. From Greece, the chills and fever were spread to Roman territory about 300 B. C. Because Rome, the city, was so splendidly located on seven hills and the marshes between the hills were effectively drained through the Cloaca Maxima, the Empire City remained free from malaria. The marshes in the nearby territory, however, were not drained and these agricoli suffered the disease regularly, daily, tertiarly or quarterly. By instinct they deserted their farms and migrated to the healthy city to escape the fever. This influx brought about congestion, idleness, corruption and vice. Plunder and dispossessing of the rich became the by-word of the Roman populace and surely laid the foundations for the downfall of the Empire. The fevers drained the initiative of the Romans, and fostered idleness with its evils. The Pontine district was changed in two generations from a prosperous district, well populated with warriors, into a wasted marshland, by malaria. A monument still in existence is the deserted ruins of Ninfa, which lies "fairy-like with its covered walls, church spires, convents and dwellings half-sunken in marsh and humming with sounds of beetles, mosquitoes and crickets." When Rome fell, their fine sewers and aqueducts were destroyed by the Goths and it then became malarious. From thence it spread to all Europe.

In the new world, too, malaria played its part. Spain conquered Peru, Brazil, Ecuador, Mexico and our own southern states easily and with but a few thousand warriors, but she failed to hold them under her yoke simply because they did not sur-

vive the old enemy, malaria. With this conquest came, however, the hope of one-third the world's people and their deliverance from fevers. So dramatic is its discovery I quote from Major on the circumstances under which it happened. "One day when a company of Spanish soldiers were marching through a Peruvian forest one soldier was seized with chills and fever. He became so exhausted he could not keep up with the company. He was therefore abandoned on the roadside to die. As his fever rose, a raging thirst overcame him. Crawling slowly through the brush he came upon a pool filled with stumps and logs and partook of the water. It was intensely bitter, but being wet he drank and continued to drink. After slaking his thirst he fell asleep, but lo, on awakening the next morning he was well! Recovering, he hastened in pursuit of his company and caught up with them, much to their astonishment. They, thinking a miracle had taken place, returned to the pool and likewise partook of the healing waters." This was the discovery of quinine because it was eventually determined that the bitterness of the water was due to the bark of the logs immersed in the brackish waters, and it soon spread among the Spanish conquistadores that the bark of this Peruvian tree cured the chills and fever. In 1638 the wife of the Count of Chinchona, viceroy of Peru, took the powdered bark and was cured of the malady. Being truly grateful she determined that it should be distributed to as many sufferers as possible and on returning to Spain continued to distribute the miraculous powdered bark from her estate at Chinchon, Spain. Although the true discoverer remains an unknown soldier, posterity still remembers this Duchess of Chinchona because scientifically quinine is known the world over as Chinchona bark. Major further states that, beautiful as the legend may be, it is not in all respects strictly true, but records reveal that the Duchess of Chinchona who was cured was not so altruistic. She did return to Spain with her physician in 1641 well supplied with Peruvian bark, which was sold from her estate at large profits. The Jesuit fathers did, however, distribute it widely and at cost. They secured a papal blessing and sanction, since which time it has been widely used, although at first it was outlawed in the most Protestant countries because

of the very fact that it had been introduced by the Jesuits and even known as the Jesuits' bark.

Closely connected with the ravages of malaria, probably because it is an insect-born disease as well as being a tropical disease, is yellow fever.

The influence on history has been no less marked through one than the other. Both have ruined complete civilizations and caused the abandonment of whole countries. The yellow jack, or "black vomit" as the disease was popularly known, was the one thing which destroyed that ancient civilization of the Mayas in Mexico. Their records preserved for us today give accounts of the frequent visits of this pestilence among them and definitely was the cause of them abandoning their cities and scattering over the country. This weakened their stand against the Aztecs of the highlands and permitted the latter to be victorious. A definite epidemic in the year 1454 practically annihilated them. The Aztecs, living as they did on highland plateaus, were keen enough to observe that they remained free from this terrible "black vomit" at home and contracted it only when carrying on war against their Mayan enemies when in the lowlands and near the sea coast.

Again the failure of Spanish supremacy in the new world can be attributed to a disease. All of the Spanish soldiers poured by the persistent Charles into Haiti and Cuba to establish a Spanish throne in the new world was futile, because immediately after landing they would succumb to yellow fever, malaria, et cetera. Indeed the history of the natives of the western hemisphere is almost identical with that of Europe in the plague days. "Black vomit" became dreaded as much by the new world explorers as had "black death" been abhorred by their ancestors. Haitian history is a definite entity to serve as an example of yellow fever's devastation. From 1500, when it was the principal Spanish settlement in the new world, to 1514, the numbers of whites in Haiti diminished from sixty thousand to less than fourteen thousand.

The next steps were the introduction of the African negroes and the beginning of the slave traffic. Since these negroes apparently had some immunity to this dread disease, "black vomit," they soon outnumbered



bered the Indians and whites and became supreme in a revolt, led by Toussaint L'Ouverture, whose story has been made familiar in Eugene O'Neill's great play "Emperor Jones." LeClerc, sent by Napoleon to conquer this nation of blacks, landed with a force of twenty-five thousand trained Frenchmen, failed utterly, not due to lack of valor on the French soldiers' part, or courage on the part of the negro defenders, but because of the negro ally, yellow fever. LeClerc returned just three months later with a mere three thousand of his original army. Because of the slave and rum traffic between the West Indies and our early colonies, yellow fever was always a menace in the cities of New York, Philadelphia and Charleston, where it occurred in epidemic proportions on several occasions, notably in 1793. In Philadelphia that year such ridiculous methods as firing of guns and burning of bonfires in the city streets were resorted to, in order to purify the air of the disease. Thomas Jefferson and Doctor Benjamin Rush were among the first to state that it was a contagious disease, localized in a circumscribed atmosphere and always along the sea coast, marshlands or navigable rivers. From these early and intelligent observations Carlos Finlay started his all-important work on mosquitos, and of course pointed the way for the work of the yellow fever commission headed by Doctor Walter Reed and James Carroll. The finding of the means of transmission of yellow jack is too well known to relate again.

Frenchman Lesseps failed to dig the Panama Canal not because he was a poorer engineer than Gorgas but because yellow fever was the killer of his men. The French lost two hundred and fifty out of every thousand men while Gorgas' death rate was only eight per thousand. Thus the first inter-oceanic highway and the awakening of the Pacifically minded world, from one formerly only Atlantically minded, was realized because yellow fever was under control. Gorgas himself prophesied that, "with malaria and yellow fever eliminated, life in the tropics for the Anglo-Saxons would be more desirable than in the hardier temperate zone. Gradually within the next two or three centuries the tropical countries, because they offer a greater return for man's labors, will be settled by white races and again the centers of wealth, civiliza-

tion, and population will be in the tropics as they were in the beginning of human history." Certain developments show the birth of this prophecy already; for example, Florida—Rome with Mussolini's swamp control about the Tiber—and, of course, the example of the Canal Zone being a health resort equal to that of New York City from its lowly epitome of "the graveyard of America."

Besides these diseases which deterred the colonization of the new world there was the sailor's disease or scurvy which undoubtedly held back the settlement of the new-found lands. The toll of the seas was not their storms and hurricanes, but disease; true enough, sanitation played its rôle, but scurvy was the real dread. It has been said, during the time previous to the age of steam, that a ship two weeks out was a hospital, one four weeks out, a morgue. Surely this must have discouraged all but the hardiest to undertake a sea voyage to distant lands where unknown dangers lay ahead. Sir Walter Raleigh's colonization voyage to Virginia in 1560 was decimated by scurvy and explains the failure of that gallant's dream. The dreaded Spanish Armada was under the spell of scurvy and thereby fell victim to the English Elizabeth's navigators. The great navigators of the same queen, Sir Francis Drake and Hawkins, aided often in their glorification of their Queen's navy, in the end succumbed to the disease of the sailors.

Cartier's band of settlers in Quebec were sick with scurvy and twenty-five died the first winter. So it was with all travelers in those days, until Captain Cook sailing around the world in 1770 solved the mystery by preventing scurvy with the citrus fruits carried along. With this voyage as evidence, English naval ships were commanded to supply limes and lemons to the navy and by this one act she remained the mistress of the seas. With the banishment of this disease there was released an immense new force and freedom of fear of travel which promulgated a great activity in the transport of people. Man's horizons were broadened and the spirit of exploration and adventure in a new country reached a peak never before or since realized. Unquestionably this was a tremendous influence on the history of the entire race.

Syphilis, too, has had its part in the mak-

ing of history and to a considerable extent remains rampant even today, though its cause and specific cure are well established. Let me briefly relate its early spread and some of its most outstanding effects on the welfare of our race. Doctor Miller's recent splendid paper delved into the history of the disease and its origin. From him, and I believe all historical writings agree, we learn that its first appearance, at least in epidemic form, was in 1494 in Naples, Italy. Here it occurred among the conquering soldiers, Germans, Poles, Hungarians, Portuguese, Frenchmen and Spaniards, led by Charles the Eighth of France, as his first step in a war to attempt the reestablishment of the empire of the east. Because the King of Naples offered no resistance and intrigue prevailed in the Neapolitan capital, these conquering hordes were welcomed and feted by the citizens in a grand manner. They were wine and dined and the maidens were attractive and willing and the army of the fifteenth century, no different than any other army, settled down for a winter of enjoyment and pleasure. After a few months the pleasure-bent army was ousted from its position by a coalition of the Pope, the de' Medici and the King of Spain. Along with this retreat, they carried the "Neapolitan Disease" back to their various homelands. Twenty years after, syphilis appeared in all classes of people, bishops, popes, kings, nobles, as well as the sailors, soldiers and strumpets, having been disseminated through the "Noble" houses of prostitution in the most ancient of manners. First, it was the existing circumstances and customs of the fifteenth century that contributed even more to its spread. The public baths of the pagan Romans, after first being crushed by the Christians, had again been revived and were flourishing better than ever before by the beginning of the sixteenth century. Every village and city had its public bath. Houses of prostitution were luxurious organizations under protection of the state and church. Agrippa wrote, "Pope Sextus built a palace of prostitution in Rome, each woman paying sixpence weekly, which amount yearly to twenty thousand ducats." This same Pope built the Sistine Chapel and founded the Sistine Choir, likely financed from these same ducats.

Cellini wrote often in his autobiography

of his own experiences and relates that it is "partial to priests, and especially to the richest of these." It is because of its infecting the powerful men of its time that its influence on history has been so stupendous. Francis the First, of France, was known to have had it and showed characteristic mental changes. His autocratic acts and massacre of his Protestant subjects, the Huguenots, in southern France and their chastisement and migration, are substantial evidence of his disease.

Again, the very religion of England is traceable to the infection of syphilis in the august body of Henry the Eighth. He, being sought as an ally by Francis the First, was invited to visit the French court, which he did. Francis supplied the visitor with a court of gold and feted the English monarch for three full weeks. Having enjoyed all pleasures of the court of France, Henry returned to England only to ally himself with Charles the Fifth of Spain, rather than Francis, but the visit had consequences even greater than this alliance failure. Doctor MacLauren explains, further, that Henry's first wife, Catherine of Aragon, daughter of Isabella and Ferdinand of Spain, who brought into the world five still-born children, and one daughter, who survived to become "Bloody Queen Mary," from her face as revealed by her portrait, suggests the stigmata of hereditary lues. Because of this failure to produce a male heir, Henry, as is known, divorced Catherine and his next choice was Anne Boleyn. Because the Pope feared to arouse the ire of Catherine's nephew, Charles the Fifth of Spain, he refused annulment of Henry and Catherine's marriage and the establishment of the Church of England resulted.

Thus had Henry the Eighth not contracted the disease, who could foretell what course the world's history might have taken? Catherine's sons would likely have lived, the King would have had an abundance of heirs, the divorce and break with the Roman Church might never have occurred. Ireland's history would have been more peaceful and even events in the American colonies might have taken an entirely different course. Certainly the destiny of nations was altered by Henry the Eighth's disease.

Likewise artists, poets and philosophers were affected and the mention of names has but little meaning, but their works stand for a great deal. Ulrich Von Hutten, the



precursor of German unity, who produced a unity of mind for the Germanic people and prepared the way for Luther's Reformation, describes the lesions of syphilis unquestionably in his writings. His book "De Morbus Gallico" to this day remains a classic in medical literature and gained a world-wide audience for him because of the wide prevalence of the "French disease" among men.

Having skimmed briefly, by taking seven league boot strides, through the ages, I have endeavored to point out some of the most astounding changes which have occurred in history directly due to epidemics of one disease or another. On the other hand, there is a much wider field to be considered in the influence of disease on history by merely mentioning a few instances of the untimely or timely death of some notable personages. The conjectures possible in these instances would stress even the most stupendous imaginations.

For instance, who can say, or imagine, what turn the French Revolution would have taken had Mirabeau been spared and not died at an early age of gout? Would the American War of the Rebellion have taken place had Chatham's mind not been darkened by the same disease when giving council to George the Third?

What a different world this might have been had Hannibal not had to deal with the marshes and fevers of the Roman Campaign on the Appian way. What might have happened had Alexander the Great not died at thirty-three years, due to a fever contracted in the marshes of Babylon? Had Attila not been stricken with hemorrhages on his wedding night when his victorious armies stood before Rome? Certainly if Emperor Maximilian had not been stricken with dysentery and died, permitting a far more religious and powerful Prince Charles the Fifth of Spain to ascend the throne, the Protestant Reformation would have gone beyond the Alps and Pyrenees and absorbed even Rome itself.

Would Napoleon's success have been so remarkable and outstanding had not every other country in Europe at that time been under the rule of either an insane or feeble-minded personage? His greatness I do not decry, but his success was due to disease just as was his downfall. Typhus destroyed his army on the invasion of Russia and his

indecision, along with Josephine's barrenness, was responsible for Waterloo.

Bonaparte's successor failed in re-establishing the Empire and saved the Republic because of a bit of gravel in the ureter. Zola ironically comments "that on a few drops of sand rests an empire's fate." The Crimean war came to an early end because of the ravages of disease and Turkey's continuance in European affairs was prolonged.

More recently would the World War have been prevented had the present Kaiser's father been spared the ravages of cancer. Certainly had he lived, Germany would have been granted a constitutional monarchy similar to that of his English cousins, and no rape of Belgium would have taken place. England would not have had the pretended excuse to join with France and the whole catastrophe might have been avoided. In the cursory sketch which only grazes a fertile field, I have tried to show the transcendent influence disease has played on history. That historians have shown little appreciation of these history-forming forces is a fact borne out by reading accounts from many sources. The reason for this is easily explained. Only in the last two generations have definite causes of many diseases been raised above a field of superstition and theoretical conjecture. As long as disease was considered an affliction of the gods controlled by fate there was little need to question their causes and effects on the woof and warp of history, because there was nothing to be done about them.

As these causes and control of disease become more apparent and better understood, and when the effect of the conquest of disease becomes more ascertainable, a new importance and intensely interesting aspect of history is available for study. That disease has been prominent in world trade, world economics and world politics, is unquestioned. I have mentioned that it has changed nations, destroyed empires, and if disease is conquered with scientific knowledge dramatically or insidiously, the consequences to countries and races is scarcely prophesiable.

Already there has been such control of disease and improvement of healing or preventing disease that the average life span has increased ten years and more. Populations are increasing and apparently the ne-

cessity of employment is decreasing, so it may be that there are too many people already. Will the tropics again overrule those in the temperate zones? If any of these things happen soon or in the distant future, it will be added evidence of the tremendous influence of disease and the con-

quest of disease upon the history of the race.

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## QUARTAN MALARIA

### Case Report

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M. D. F., a four-year-old girl, living on the east side of Detroit, gave a story of having regular spells of chills and fever at three-day intervals. These began after a moderately severe but uncomplicated case of measles one month previously and increased in severity so that the child would come in from play on the afternoon of such spells, complain of headache, lie down, become very hot, and then shake sufficiently hard to rattle her crib bed. Her temperature had not been taken. Within three hours the child would feel quite well and would act normal until the next attack occurred. The usual questions relative to her past history revealed that she was born at home, instruments having been used, that she weighed 8½ pounds, and that she was normal in all respects. In infancy she had always vomited easily. The only other serious illness was a purulent cervical adenitis when two years of age.

This child was brought to the office during the interval between attacks and at that time physical examination showed a well nourished girl of four years. Her weight at 36 pounds was 2 pounds above the average for her height and age. The liver could be palpated about the width of one finger below the costal margin and the spleen was at the level of the umbilicus at the lowest point. All other findings were normal. At this time her blood showed 13.5 gm. hemoglobin, 4,000,000 red cells, 6,400 white cells with 8 per cent polymorphonuclear and 92 per cent lymphocytic leukocytes. The urine was normal. An intradermal tuberculin test proved negative in five days. When she returned during an attack smears were made which showed considerable numbers of malaria parasites. The diagnosis of quartan malaria was made.

Subsequent questioning as to the possible source of the infection revealed that the child had never been farther south than Toledo, Ohio, and that no person with whom she had ever come in contact had had any similar symptoms according to the knowledge of the mother and the maternal grandmother. The parents were separated and the father had custody of the child one day each week. From him it was learned that when the patient was three days old she was given an intramuscular injection of blood taken from him because of some blood in the stools. The

father was a native of Sicily and during childhood had had malaria but had not had symptoms nor treatment since the age of 18 years.

Since the quartan type of malaria is rare in this country and since this type is well known to be difficult to completely eradicate, it is quite likely that the infection was transmitted from the father to the child through the intramuscular injection of blood, even though no symptoms arose until four years later. It is possible that transmission could also have occurred through the medium of the *Anopheles* mosquito, but the former method seems the more probable.

The child responded quickly to quinine so that there were no symptoms after two weeks of treatment. When last seen after ten weeks the spleen was barely palpable but not tender, and the child had gained one and one-half pounds in weight.

The story of this case is put on record to call attention to the fact that prospective donors of blood, even for intramuscular injections, should be carefully questioned as to the possibility of latent malarial infection.



## OFFICE SECRETARY'S PSYCHOLOGY WITH PATIENTS AND VISITORS\*

HENRY C. BLACK

BATTLE CREEK, MICHIGAN

It will be impossible to do more, in this short time, than to touch briefly on some of the more important points of this subject, and if possible bring out some questions for the round table discussion which follows. There is much to be said on this particular phase of psychology, and yet whether it be in the doctor's office or in any other similar situation, the fundamental principles involved are the same.

The first impression a patient receives is most important, and much can be done by the receptionist or secretary to make the impression a favorable one. Patients coming into the office are ill and uncomfortable and should be greeted by someone immediately, told whether the doctor is in, and how long it will be necessary to wait. They should be made to feel at home, put at ease, and their time conserved as much as possible. The ability on the part of the receptionist to anticipate and answer their questions in a business-like, yet sympathetic manner, lends an air of competency and reassurance which has far-reaching results.

Often visitors to the office need not necessarily see the doctor at all, if payments are to be made on their account, or appointments are desired, in which case there should be no waiting. It is the duty of the receptionist to determine diplomatically the reason for the visit and dispose of the purely business calls with dispatch. Due to the comparatively short time the doctor is able to spend in the office, that time as well as the time of his patients should be conserved.

Some of the doctor's success in getting and holding his patients depends upon the manner in which the telephone is answered. There have been cases where a patient calling for the doctor is merely told, "The Doctor is not in," whereupon he hangs up and may or may not ever call again. How much better to have said, "Dr. Blank is out right now but I think I can reach him. Is it anything urgent?" A continuation of the conversation very likely would arrange for an appointment, or at least a satisfied feeling on the part of the patient, even though it was necessary to wait some time for the doctor.

The basic principle underlying the success of the private practitioner is that personal and confidential relationship between doctor and patient, and the competent secretary may be of great assistance in that relationship. Patients like to feel that they hold the doctor's special interest, that they are not just average cases like Mr. Jones or Mrs. Smith, but particular patients deserving of particular attention. The secretary or receptionist may often help to satisfy this desire, and it is a simple matter to make them feel that everything is being done to make them feel at home, take care of them promptly, and see that they get the special service they feel they deserve.

It is often difficult to pick out from the many callers those who must see the doctor professionally, those salesmen and detail men whom the doctor frequently needs to see, and those who will only take up the doctor's time unnecessarily. Regardless of the reason for the call, all visitors should be treated courteously, whether patients or not, and if arrangements cannot be made to see the doctor, at least they should be told so courteously and sent away happy.

Then there is the situation which very often arises when an emergency makes it necessary for the doctor to leave during office hours. In this case the patients in the waiting room should be informed of the situation with a proper explanation, and not left ignorant of the fact that possibly an hour or two

hours will elapse before they can be seen. Their time is just as valuable to them as the doctor's is to him, and if properly advised they may possibly utilize the time to good advantage elsewhere and come back at a more appropriate time. At least they will be much less apt to feel that they were unfairly treated.

When patients call in for appointments and are prompt in keeping them, they highly resent having to wait because others who possibly arrived earlier but without appointment are taken in ahead of them. It is one of the duties of the doctor's assistant to make workable appointments, and then to allow nothing but the extreme exception to prevent these appointments from being kept. There is no place for favoritism in the order of taking care of patients without appointments, and the rule must be, in such cases, strictly "First come, first served."

I have seen offices where certain select friends had access to the office through a back door, supposedly without the knowledge of other patients waiting their turn in the waiting room. This frequently breaks up the continuity as well as the efficiency of the office and should in most cases be discouraged.

An example of the benefits of correct psychological approach to common everyday situations may be demonstrated in the conversation incident to accepting payments on accounts. All of you have had patients stop at your desk, throw down a dollar bill and say, "I'll be in again in a couple of weeks," a remark intended as just a casual comment indicating further payment if and when convenient. The really clever office assistant will turn this statement into a definite promise to pay in some such manner as this, and without ever asking for it. She will say, "All right, Mr. Smith, I'll note that on your account. Let's see, that will be the 4th of October. (Noting it down.) Thank you very much indeed, and we'll look for you then." The result is that the patient has been courteously impressed with *his own* arrangement in so definite a manner that a letter can be sent him a few days later if the promise is unfulfilled.

Speaking of letters, the psychological importance of correspondence to patients cannot be overlooked, and although the question of collection procedures is to be discussed by another speaker later on in this symposium, let it be said here that the way letters are written to patients who are slow in paying their accounts can affect not only the cash receipts from the letters themselves, but the good will and the success of the practice. Again, the personal relationship of the doctor and patient is the basis on which the successful correspondence depends.

\*Read before the Annual Meeting of Michigan State Medical Society, Detroit, September 19, 1938.

EDITOR'S NOTE: This paper contains excellent suggestions. Have your office assistant read it.

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*"Every man owes some of his time to the up-  
 building of the profession to which he belongs."*

—THEODORE ROOSEVELT.

## EDITORIAL

### THE LESSON

THE medical profession all over the United States probably took a greater interest in the outcome of the election in November than at any previous time and this does not mean of necessity political partisanship. The impression is abroad that there is a nationwide attempt to socialize medicine with as much speed as opposition and finances would permit, and there was a feeling that Michigan would be in the vanguard in this matter. If the general election meant anything at all, it meant among other things, of course, that the United States is opposed to carrying socialistic plans too far; and despite all that has been said about the passing of individualism, that there is still a strong feeling to the

effect that individual effort and initiative should be fostered and encouraged.

A declaration of principles was made by the rival parties in this state. The Republicans incorporated into their platform a paragraph relative to medical care. We feel that this declaration is sufficiently broad, and at the same time sufficiently definite, that the medical profession of the state can feel confident that no legislation unapproved by and unacceptable to the medical profession and allied professions will be enacted. The profession strongly approves all procedures to provide essential medical care to all groups, but these procedures must be in conformity with approved standards. The pre-election declaration of the Republican party of the state, reiterated in substance since the election, runs as follows:

"We believe that it is the duty of the Government of Michigan in so far as it is possible to favor private employment of the citizens so that they can pay for their own medical care. Whether citizens are able to purchase medical care independently or whether, as in case of those on other types of Government relief, it has to be furnished at State expense, we hold to the principle that every citizen has the right to good medical care and that he has the right to select his physician.

"We believe that the problems of medical care are best understood by the Medical and Allied Health Professions and that the plans for the carrying out of such care should be directed by these professions.

"We believe further that it is the duty of the Government of Michigan to assist and not to direct these professions in bringing to the people, particularly those dependent on the Government for other types of relief, such as food, clothing, shelter and fuel, the best possible medical care consistent with sound financial policy."

There was probably never a time in the history of the state when retrenchment has been so necessary. We have arrived at the stage when necessary public services are cramped for lack of funds. Socialization would simply add to the load.

It is well known also that the federal government has been asked to appropriate huge sums for medical service throughout the nation. What the federal government will do, no one can anticipate at the present time. From a statistical study of the past year, the health of the people of the United States has been better and the morbidity and mortality ratio has been lower than ever before, therefore the appropriation of huge sums for a health program cannot be viewed as an emergency expenditure.



## POSTGRADUATE MEDICAL EDUCATION

THE advisory committee on postgraduate medical education have drafted a plan on a unit system of credits permitting 15 units in any one year. In fact, this is the minimum requirement for a certificate for associate fellowship in postgraduate medical education. The plan has been approved by the Executive Committee of the Council of the Michigan State Medical Society and authorized by vote of the House of Delegates.

Physicians are encouraged to attend the various medical society meetings to which the following values have been attached. (1) Attendance at County Society meetings (60 to 75%)—2 units; (2) Annual meeting of State Medical Society—1 unit; (3) American Medical Association—1 unit; (4) At Postgraduate Conferences—1 unit; (5) Attendance at a recognized national meeting—1 unit; (6) Attendance on 75% or more of the Extramural Program—15 units; (7) Attendance on yearly composite course—15 units; (8) Attendance on intensive special courses in Michigan Program—each 5 units; (9) Attendance on formal special courses in recognized specialty to which the attendant limits himself—15 units; (10) Membership in and attendance on approved educational societies and activities—1 to 5 units; (11) Membership and regular attendance on accredited hospital staff conferences—2 to 10 units; and (12) Awarding of Fellowship in Postgraduate Education to members of the Michigan State Medical Society on the basis of research and activities on the Michigan postgraduate program; the first of such awards to be made in 1939.

There is a great deal to be said in favor of evaluating postgraduate work in terms of units. Where the student does not submit to an examination, it is a practical method of checking up on the progress he has made since his graduation from medical college. Attendance upon medical meetings is in reality of greater importance than attendance upon classes in the undergraduate medical school. It means more to a practicing physician than the same presentation would mean to the undergraduate who has not yet found himself.

The requirements for certification are not

made too easy—four years of attendance on various medical meetings; nor, on the other hand, are they so exacting that the busy practitioner cannot avail himself of the opportunity for attendance.

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## WE STILL HAVE FRIENDS

OF RECENT years in spite of the scientific advancement of medicine and the fact that the general health of the people of the United States was never better, the medical profession has been the target of much adverse criticism. There has been a great amount of shallow thinking or perhaps better, emotional thinking, if the two words may be employed together. A lot of it has appeared in high grade magazines from editors of which one would expect finer editorial discrimination than has been exercised in the acceptance of such articles.

However, among those publications which have seen fit to publish papers which set forth the true spirit of scientific medicine is *Life*, one of the most influential publications of the kind in the United States. The October 24 number of *Life Magazine* contained a very interesting, eight-page study of animal research in medicine and surgery with statements from a number of the leading minds in American medicine. It goes without saying that such articles wield a great influence in promoting public welfare in matters of health in the dissemination of true information of the evolution of scientific medicine.

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## HASN'T MEDICINE A PART IN IT?

UNDER the heading "Disgustingly Healthy," the *New England Journal of Medicine* mentions the fact that 1937, the eighth year of the depression, according to the Bureau of Census, found the death rate of infants the lowest in the history of the United States, namely, 54.4 deaths for every 1,000 live births. A newborn baby has a third better chance to reaching its first birthday than in the normal year 1925. Quoted in the November number of THE JOURNAL of the Michigan State Medical Society is a statement by Dr. Haven Emer-

son to the effect that not only infant survival but the general health of the nation has been better during the first half of 1938 than at any time in the past. The *New England Journal of Medicine*, taking the *New York Times* to task, maintains that all this cannot be ascribed to the credit of the capitalist state.

"Neither can it be said, despite the *Times*' implication, that because improved health has come under capitalism it has come because of it. 'In length of life and in health the masses prospered under the so-called *laissez faire*,' is a statement that smacks of smugness. The fact that the road has been slowly upward under our own system of capitalism does not put a complete stamp of approval on its conduct of the nation's business."

Perhaps not. Can it not be taken, however, as evidence that organized medicine has not been recreant to its trust?

#### PARTLY TRUE: LARGELY FALSE

"BOTH the rich and the poor get good medical care. The poor may obtain it free and the rich can pay for it. It is the great middle class who are embarrassed in the instance of confining illness." How often do we hear this? It has been repeated *ad nauseam* by uncritical people with whom acceptance of a slogan is much easier than first-hand examination to ascertain the truth or falsehood of it.

The fact is the indigent as a rule get a lequate treatment; as regards the best it is too much to expect. For instance, when medicines are prescribed they get the simpler drugs rather than the refined and expensive products of the pharmaceutical manufacturer. The rich may, but do not always, get the best and in some instances do not get as good medical care as the indigent, for often they call on the substandard care of the cult or the faith healer which is anything but scientific.

The great middle class by and large who pay for their medical care get the best. Health is too important a matter with the majority of them to waste their time and means on substandard cult healers.

Medical tradition has long been such that physicians place service before the emolument, consequently the wind of the doctor's fee is usually tempered to the shorn lamb, either by a substantial reduction or a lengthened period for payment.

#### COMMERCIAL RESEARCH

THE writer attended a meeting recently at which the speaker, a man of scientific attainments with a national reputation in his specialty, praised very highly the work and willing coöperation of an industrial firm, manufacturers of apparatus for the use of members of the medical profession. The firm, he said, had spared no effort nor expense to produce the particular apparatus to meet the purpose required. This calls to mind the fact that the first x-ray apparatus was more or less improvised and crude. Thanks to the efforts of manufacturers who financed research along various lines such as physics, engineering, electricity, photography and chemistry and even biology, we have the powerful and efficient equipment that may be seen today in the office of any roentgenologist or in any hospital. Evolution of apparatus, with refinement in control and measurement, has in time made possible greater skill and advancement in the science of radiology. The same may be said of the electrocardiograph. How often does it happen? Ideas and illustrative drawings and specifications emanate from the physician or surgeon only to have the manufacturer seize upon the idea and the result is so surprisingly satisfactory as to be beyond expectation. A great deal of present-day research is carried on in colleges equipped for the purpose; however, not all by any means. Much of it is accomplished by pharmaceutical firms who sometimes spend millions of dollars on buildings and equipment and securing the best trained personnel for the purpose. True, the purpose may be to produce in the end a product of the highest merit to command a price. However, in doing so a service is performed from which the whole world may benefit.

The writer is aware of the attitude of the scientific mind that research is a matter of ascertaining the truth regardless of any utilitarian purpose it may serve. Much research never really gets beyond this.

We wonder at times and shudder at the possible effect of socialization with its high taxation and tendency to level down, in cramping commercial altruism (why not the term?) that has produced such gratifying results. Much of the material progress the end-result of scientific research is due to financing by the profits of industry. Many scholarships and fellowships available to able and talented students in our universi-



ties would have been impossible otherwise. Tax so-called excess profits, socialize medicine and everything will be reduced to drabness. There will be little or no funds, and there will be little incentive towards excellence.

THE year draws to a close and with it the fiscal year of probably the majority of county medical societies throughout the entire state. This brings up the subject of society annual dues. The county societies together with the Michigan State Medical Society have been increasingly more active in the interests of their members. The demand becomes greater for prompt payment of membership dues. The largest fee charged is thirty dollars a year and that in Wayne County. Even this is a small fee compared with that paid by organized craftsmen in industry. The annual dues of each typesetter, compositor, make-up man and printer of this JOURNAL are fifty dollars. Compare this amount, doctor, with what your county society expects of you.

#### AESCULAPIUS TRUMPS

Oh spare me from the blatherings  
Of those who, while at gatherings  
For bridge, discuss their appendectomies.  
I'll rate as four-star minuses,  
Those sufferers with sinuses  
Who jeer with scorn mere tonsilectomies.

From those whose pet psychosis  
Is their grandpappy's thrombosis  
Or a recently discovered allergy;  
Who discuss their rheumatism,  
And their aunties' aneurysm,  
May I forevermore delivered be!

To those whose whole exterior,  
Both frontal and posterior,  
Is seamed with stitches large and stitches small,  
May I say that operations  
Forming inter-deal orations  
Have most decidedly begun to pall.

Come, let us in the future  
Have our bridge without the suture,  
The scalpel and the therapeutic ray.  
If you wish, before and after,  
Diagnose and heave the rafter,  
But while the game is on, SIT IN AND PLAY!  
—Helen Hawthorne in *McLean's Magazine*.

#### It's An Idea

The police of Zagreb, Jugoslavia, require violators of traffic ordinances to pull over to the side of the road and deflate all tires. The number of accidents on the streets of this city has fallen considerably.  
—*United States Municipal News*.



## The Editor's Easy Chair

#### ILLUSTRATIVE VERSE

ELSEWHERE in this number of THE JOURNAL of the Michigan State Medical Society we have reviewed a real scientific book entitled, "Big Fleas Have Little Fleas," which calls to mind the frequency with which scientific men have resorted to verse, some good and some bad, to illustrate their meaning. The author of the lines on the Parasitic Flea was Jonathan Swift, who lived during the latter part of the seventeenth century and the first half of the eighteenth. He is well known as the author of "Gulliver's Travels." He also won the reputation of being England's greatest satirist. The complete stanza runs as follows:

"So, naturalists observe, a flea  
Hath smaller fleas that on him prey;  
And these have smaller still to bite 'em,  
And so proceed *ad infinitum*."

A later rhymmer, De Morgan, who lived during the nineteenth century, carried the jingle a little farther:

"Great fleas have little fleas upon  
their backs to bite 'em.  
And little fleas have lesser fleas,  
and so *ad infinitum*.  
And the great fleas themselves, in turn,  
have greater fleas to go on  
While these again have greater still, and  
greater still and so on."

Another verse that has become current coin with students of psychology and physiology illustrates the fact that where we interfere with an act which is usually involuntary, we immediately get into trouble:

"The centipede was happy quite  
Until a toad in fun  
Said, 'Pray, which leg goes after which?'  
That worked her mind to such a pitch  
She lay distracted in a ditch,  
Considering how to run."

The author was a Mrs. Craster in *Casell's Weekly*, an English publication, the date, 1871.

\* \* \*

The subject of heredity has been much discussed by the biologist and the medical

profession since the discovery of the epoch-making work of John Gregor Mendel, which laid buried in an obscure magazine where it first appeared in 1866. The author of the current scientific conception of heredity was an Austrian monk who died in 1884; his work was not discovered until many years after his death.

Vision a biologist or any scientifically-minded person standing before a century-old portrait of a coy damsel of the time, uttering the following monologue:

"Oh, Damsel Dorothy! Dorothy Q!  
Strange is the gift that I owe you;

What if a hundred years ago  
Those close-shut lips had answered 'No.'

Should I be I, or would it be  
One-tenth another, to nine-tenths me?"

"Soft is the breath of a maiden's yes;  
Not the light gossamer stirs with less;  
But never a cable that holds so fast  
Through all the battles of wave and blast,  
And never an echo of speech or song  
That lives in the babbling air so long!  
There were tones in the voice that whispered then  
You may hear today in a hundred men."

Of course, everyone familiar with the work of Oliver Wendell Holmes will recognize the lines on Dorothy Q.

\* \* \*

Or note the significance of nurture in its struggle with nature (inheritance) in the following:

My ancestors lie buried on a hill  
High and green, and they lie in rows  
Tucked in under the waving grass.  
Why don't they stay there? Goodness knows!  
But they steal behind me, their fingers poke  
Into my business. What they want goes.  
Aunt Maria she liked to scrimp,  
Uncle Abner he liked to pray,  
Fussy old Jonathan Pettiboe—  
All of them try to boss the way  
I live my life—Well, it can't be gay.

How can I call my life my own  
When the scheming dead try to live through me?  
How can I know what I really am  
With their wishes hounding me greedily?  
Though I think them dead, they're not, they live—  
Parasites having their way with me.

The following little poem on "Heredity" by Thomas Bailey Aldrich, an American poet who died in 1907 at the age of seventy-six years, also fits in with the discussions on the subject of heredity.

A soldier of the Cromwell stamp,  
With sword and psalm-book by his side,  
At home alike in church and camp:  
Austere he lived, and smileless died.

But she, a creature soft and fine—  
From Spain, some say, some say from France;

Within her veins leapt blood like wine—  
She led her Roundhead lord a dance!

In Grantham church they lie asleep;  
Just where, the verger may not know.  
Strange that two hundred years should keep  
The old ancestral fires aglow!

In me these two have met again;  
To each my nature owes a part:  
To one, the cool, and reasoning brain;  
To one, the quick, unreasoning heart.

Many other examples might be given. Probably, however, Lewis Carroll's whimsical verses in *Alice in Wonderland* are used as illustrative material more than any other inclusions from poetry and near poetry. One might almost conclude that *Alice in Wonderland* and Lewis Carroll's other works are part of the education of a scientist. We have even seen phraseology quoted in scientific books and papers which we recognize as originating with Gilbert and Sullivan.

#### IF YOU'RE NOT APPRECIATED CONSIDER SHAKESPEARE

Goldsmith declared him absurd.  
Many called him an upstart crow.  
Hume called him a misshapen giant.  
Voltaire said he was a drunken savage.  
Byron openly sneered at him and roundly denounced him.  
Dryden said he wrote "below the dullest writers of our age."  
Sardou called *Hamlet* "an empty wind-bag hero."  
Pepys said that *Romeo and Juliet* was the worst play he had ever heard.

—*Your Life*, New York.

#### CHRISTMAS

Oh gi' me a Christmas wi' snow and wi' ice,  
A day that is cold, but sunny and nice;  
And friends wha' are willin' tae frolic a' day,  
And horses tae drive in an auld bobsleigh.

Ye may hae yer steam heat in yer two-family flat,  
Yer bathrobe and slippers and yer aul turkish mat;  
But gi' me a muffler, a blanket, and hay,  
Wi' horses and bells and an auld bobsleigh.

I ken I am auld, decrepit and creak,  
But it's Christmas tae me—nae time for defeat;  
Ye may tak yer auld auto and stow it way,  
But gi' me my horses, my bells, and a sleigh.

Oh, we need Santa Claus tae come in the night  
Tae fill a' the stockings afore it's daylight,  
And prancing bay horses and an auld bobsleigh  
Wi' bells that will jingle—for a guid Christmas Day.

WEELUM.



# President's Page

## SEASON'S GREETINGS

**A** NOTHER year has nearly completed its course. It is always well to take stock of our liabilities and assets at stated intervals. Are we solvent? What represents our gains—our losses? Our gains must be measured in terms of our contribution to society. Our losses in terms of where we have been unable or failed to render service or to improve our position for rendering service.

We are gaining in scientific knowledge; we are becoming more social minded; we see the problems presented to us in the light of the whole field of physical and emotional pathology.

Our losses have been minor. In a few instances we have lost sight of true objectives. In some places we have been retarded by common enemies to social progress. On the final balance sheet we are still in black ink. We have reason to be proud of our accomplishments and assets.

The Season's Greetings are extended to one and all, and the hopes for the ensuing year will stay high as long as we maintain our objectives of education and of service to humanity—which our training and experience have taught us is the best method of distribution.



President, Michigan State Medical Society

# DEPARTMENT OF SOCIETY ACTIVITY

L. FERNALD FOSTER, M.D., Secretary

## THE STORY OF HEALTH

THE story of health and medical care is best understood by and can best be told by members of the medical profession. The physician, by virtue of his training and experience, recognizes the health needs of the public and appreciates by what means they can best be met.

The intriguing subject of health has been made the object of discussion by many lay groups and has received unusual press publicity in recent months. Unfortunately, the authors of many articles on health are ill-prepared to give the facts and have often developed a distorted public opinion on the subject.

Since a true presentation of facts becomes the privilege and responsibility of the medical profession, it behooves each physician to keep abreast of medical progress, both scientific and social, and to develop an ability to both write and speak the story. Some physicians feel inadequate, from the public speaking standpoint, to present their knowledge to lay groups. If this be true, why not follow the example of some of our progressive societies and develop courses in Public

Speaking for physicians? This will make it possible for them to present interestingly, to the public, the facts which they alone know best.

Organized medical groups have requested the opportunity to present their story to the layman. Let's be prepared.

## IODIZED SALT

FOR some time the Michigan State Medical Society has been collaborating with others in the study of iodized salt. The studies are familiar to most of the members of the State Society; but recently we learned of the appreciation this work has received throughout this and other countries.

A nationally known Town Hall lecturer has paid tribute to the Michigan State Medical Society and its collaborators for a most remarkable contribution to the knowledge of goitre and its prevention.

The Iodized Salt Committee has been untiring in its research and it is only fitting that we acknowledge, here, our appreciation of its fine work and its international recognition among scientists.

## ANNUAL MEETING OF THE COUNCIL

September 18 and 20, 1938

### HIGHLIGHTS:

1. Executive Committee of The Council Reëlected: P. R. Urmston, M.D., Chairman; Vernor M. Moore, M.D., Vice Chairman; Henry R. Carstens, M.D., Chairman of the Finance Committee; I. W. Greene, M.D., Chairman of the County Societies Committee; A. S. Brunk, M.D., Chairman of the Publications Committee; and Philip A. Riley, M.D., Speaker of the House of Delegates.
2. Report given on "Michigan Health Conference" held in East Lansing, September 10, 1938.
3. Report presented on special meeting of A.M.A. House of Delegates, Chicago, September 16-17.
4. Approval of 1938-39 M.S.M.S. committees.
5. Decision made on membership transfers from other states.
6. Thanks voted to essayists, arrangements committee, and all who in any way aided to make the 1938 M.S.M.S. Convention such an outstanding success.

1. *Roll Call.*—The Annual Meeting was called to order on September 18, 1938, by Chairman Urmston in the Founders' Suite of the Book-Cadillac Hotel, Detroit, at 8:15 p.m. Councilors and officers present included Drs. P. R. Urmston, V. M. Moore, A. S. Brunk, W. E. Barstow, F. T. Andrews, Henry R. Carstens, H. H. Cummings, I. W. Greene, Wilfrid Haughey, T. F. Heavenrich, Roy H. Holmes, W. A. Manthel, J. E. McIntyre, P. A.

Riley, E. F. Sladek, Geo. A. Sherman, Henry Cook, Henry A. Luce, L. Fernald Foster, and M. H. Hoffmann. Also present were R. G. Leland, M.D., of the A.M.A., B. R. Corbus, M.D., Larry C. Salter, and Executive Secretary Wm. J. Burns.

2. *Minutes.*—The minutes of the September 9 meeting of the Executive Committee were read and approved.



3. *Bills Payable*.—Bills payable were presented and ordered paid.

4. *"Michigan Health Conference."*—The Chair called upon President Cook to report on the "Michigan Health Conference" held at East Lansing on Sept. 10. Dr. Cook explained the reason why the conference was called and reviewed briefly the results.

The Chair also called upon Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A.M.A., to give his impression of the Conference. Dr. Leland stated he was very much impressed by the large number of physicians present and their intense interest. The meeting was very well conducted and resulted in favorable discussion. Dr. Leland cautioned that there might be some danger in the resolution re establishment of diagnostic centers. These are valuable if kept within bounds, but they may be used as an entering wedge for more clinic service. The difficult job which lies in the future is putting the recommendations of the Conference into effect. This will require even more hard work than the development of the excellent Conference program. Dr. Leland was thanked for his remarks.

5. *Report of A.M.A. Delegates*.—The Chair called upon Dr. Luce for a report of action of the A.M.A. House of Delegates at its special session in Chicago on Sept. 16 and 17. Considerable discussion ensued relative to the mimeographed copy of the "Report of the Committee to Consider the National Health Program."

Motion of Drs. Carstens-McIntyre that this matter be referred to the A.M.A. Delegates from Michigan, with the request that they get an official report, and present it to the Michigan House of Delegates as their report of the action of the A.M.A. Committee to Consider the National Health Program. Carried unanimously.

6. *Report of Medico-Legal Committee*.—The monthly report of this committee was read. Motion of Drs. Carstens-McIntyre that the report of the Medico-Legal Committee be received. Carried.

7. *Supplemental Report of Committee on Postgraduate Medical Education*.—This report was read by Dr. Cummings, and The Council instructed Dr. Cummings to present the report to the House of Delegates.

8. *Supplemental Report of The Council*.—This report was read by the Executive Secretary. The report was discussed and after one minor correction, motion of Drs. Haughey-McIntyre that the report be approved for transmittal to the House of Delegates. Carried unanimously.

9. *Resolutions of Woman's Auxiliary*.—A letter from Dr. H. S. Collisi, Chairman of the Advisory Committee to Woman's Auxiliary, enclosing resolutions proposed to be presented to the Woman's Auxiliary this week, was read. With reference to the suggested resolution urging the study and presentations to lay groups of the theory and practice of socialized medicine in foreign countries and its possibilities if adopted in the United States; Motion of Drs. Moore-Holmes that The Council approves the dissemination of authentic information re the disadvantages to the people of certain systems of medical practice being tried in other countries, and respectfully suggests that this information may be obtained from the Public Relations Committee of the Michigan State Medical Society, which offers its help in this work; also that the M.S.M.S. Council expresses itself as not being particularly favorable to the resolution urging school boards to accept a textbook on the subject of tuberculosis. Carried unanimously. The proposed amendment to the by-laws of the Woman's Auxiliary was presented, and approved on motion of Drs. McIntyre-Moore. Carried unanimously.

10. *Speaker at Memorial for the late Senator Royal S. Copeland*.—The request for a speaker from the M.S.M.S. at a dedication ceremony in honor of former Senator Copeland at Dexter was presented. Motion of Drs. McIntyre-Carstens that the Chairman of The Council appoint a representative of the State Society to speak on this occasion. Carried. The Chairman appointed President Henry Cook.

11. *Group Hospitalization Plans*.—Executive Secretary Burns reported that the Michigan Farm Bureau is interested in group hospitalization.

12. *Membership*.—Dr. Carstens presented the matter of the various types of membership in Wayne County. No action was taken.

13. *Civil Service Announcements*.—Executive Secretary Burns reported several announcements of the Michigan Civil Service for physicians.

14. *Recess*.—Motion of Drs. McIntyre-Carstens that the meeting recess until called by the Chairman. Carried unanimously. The meeting was recessed at 11:20 p.m.

#### Minutes of Meeting September 20, 1938

15. *Minutes*.—The minutes of the meeting of the Council of Sept. 18 were read and approved.

16. *1938-39 Committees*.—Dr. Luce presented his proposed committee appointments for the coming year, which were carefully considered. Motion of Drs. McIntyre-Heavenrich that the committee appointments as presented be confirmed. Carried unanimously.

17. *Membership Transfer*.—The transfer of membership to the Michigan State Medical Society from other states where dues have been paid for the entire year was discussed, the question being: "Should these physicians be required to pay dues in the M.S.M.S. after having paid dues for the entire year in the other state?" After considerable discussion, motion of Drs. Sherman-Holmes that any physician who transfers from another state to this state shall pay his proportionate dues to the Michigan State Medical Society for the balance of that year. Carried unanimously.

#### 18. *Reorganization of The Council*.—

(a) Dr. P. R. Urnston was reelected Chairman of the Council, on nomination of Drs. Carstens-Heavenrich, et al. Carried unanimously.

(b) Dr. Vernor M. Moore was reelected Vice Chairman of the Council, on nomination of Drs. Holmes-Cummings, et al.; carried unanimously.

(c) Dr. Henry R. Carstens was reelected Chairman of the Finance Committee of The Council, on nomination of Drs. McIntyre-Cummings, et al.; carried unanimously.

(d) Dr. I. W. Greene was reelected Chairman of the County Societies Committee of the Council, on nomination of Drs. Holmes-Brunk; carried unanimously.

(e) Dr. A. S. Brunk was reelected Chairman of the Publications Committee of the Council, on nomination of Drs. Greene-Holmes. Carried unanimously.

19. *P. G. Certificates*.—Motion of Drs. Brunk-Moore that no action be taken on application for certification in P. G. education until the applicant is certified by the county medical society to the State Society as being in good standing. Carried unanimously.

20. *Vote of Thanks*.—A vote of thanks was expressed by The Council to all the Essayists on the program of the Annual Meeting in Detroit, to the Wayne County Medical Society as host, to the Local Committee on Arrangements, to Dr. J. D. Bruce in conducting the Postgraduate Convocation, to the Radio Committee and the Twenty-one physicians who gave addresses over Detroit Stations, to the Detroit Convention Bureau, the Book-Cadillac



Hotel, the Press Committee and newspapermen, and all others who in any way contributed to the success of the 73rd annual convention.

21. *Adjournment.*—The meeting was adjourned.

### COUNCIL AND COMMITTEE MEETINGS

1. Wednesday, October 19, 1938—Executive Committee of The Council—Hotel Olds, Lansing—2:30 p. m.
2. Thursday, October 20, 1938—Representatives to Michigan Health League—Hotel Olds, Lansing—6:30 p. m.
3. Wednesday, November 2, 1938—Maternal Health Committee—Statler Hotel, Detroit—12:00 noon.
4. Thursday, November 10, 1938—Mental Hygiene Committee—Henry Ford Hospital, Detroit—6:30 p. m.
5. Sunday, November 13, 1938—Preventive Medicine Committee—Statler Hotel, Detroit—3:00 p. m.
6. Wednesday, November 16, 1938—Committee on Distribution of Medical Care—Statler Hotel, Detroit—12:00 noon.
7. Wednesday, November 16, 1938—Executive Committee of The Council—Statler Hotel, Detroit—3:00 p. m.
8. Wednesday, November 16, 1938—Cancer Committee—Women's Club Bldg., Ann Arbor—6:30 p. m.
9. Thursday, November 17, 1938—Legislative Committee—Hotel Olds, Lansing—3:00 p. m.
10. Monday, November 28, 1938—Representatives to Joint Committee on Health Education—W.C. M.S. Building, Detroit—12:15 p. m.
11. Sunday, December 4, 1938—Advisory Committee on Syphilis Control—Hotel Olds, Lansing—3:00 p. m.
12. Tuesday, December 13, 1938—Cancer Committee—Woman's Club Bldg., Ann Arbor—6:30 p. m.

### MUSKEGON PLAN FOR MEDICAL CARE OF INDIGENTS

The Muskegon County Medical Society have a comprehensive plan for the care of the indigent sick. Before marking out a plan, an exhaustive survey was made, when it was found that there were forty-two different units or agencies in existence for the purpose of providing medical relief for the indigent sick. With so many agencies operating, the tendency was to shift the burden from one to another, but finally it devolved upon the physician to take care of the medically indigent, who gives of his time and experience, often money, while other agencies providing the necessities of life such as the grocer, landlord, coal dealer, etc., are paid. This, it goes without saying, was a highly unsatisfactory condition.

Under the new method, any one of the forty-three or more agencies to which the medically indigent might apply would first send the patient to his family physician, thereby preserving the physician-patient relationship. In an instance in which the patient had no special physician, he was given the privilege to select any physician, who, in turn, might take care of him as a charity patient. If, in the physician's opinion, the patient required medical care or hospitalization, and the physician felt that he did not care to take the applicant as a charity patient, the latter would be referred to the central office in charge of a coördinator. The coördinator would be an employee of various governmental units supplying funds for the medically indigent. The coördinator would determine whether or not the responsibility lies with Muskegon County. The responsible unit would be called upon to pay the bill. The coördinator's term of office would be from three to five years.

The report of the medical committee of the health division of the Muskegon Community Council and the report of the Allied Health Group Committee of the Muskegon County Medical Society go into detail in regard to the development of the plan.

## WOMAN'S AUXILIARY

President—Mrs. P. R. Urmston, 1862 McKinley Avenue, Bay City, Michigan  
Sec.-Treas.—Mrs. R. E. Scrafford, 2210 McKinley Ave., Bay City, Michigan  
Press—Mrs. J. W. Page, 119 N. Wisner Street, Jackson, Michigan

### CHRISTMAS GREETINGS

To the hundreds of physician's wives who have banded together throughout the State, earnestly serving the needs of the medical profession, and to the thousands of doctors so willing to assist us, it gives me great pleasure to send Christmas greetings.

At this season of the year we are all busy with plans to make the holiday season happy and joyful for our families and friends.

May each and every one have a delightful Christmas.

When the holidays are over I do hope to have advice from all committees, as to their plans, progress or suggestions which will be carefully considered, allowing me to plan far in advance for a successful annual meeting next September.

(Mrs. P. R.) LOUISE T. URMSTON,  
*President.*

### GREETINGS AUXILIARY MEMBERS

Your Secretary-Treasurer wishes to tell you again that national headquarters will supply you with program material on request. Also, speakers can be obtained for your programs for your Public Relations and Health Education activities by writing to Mrs. Harrison Collisi, 121 College N. E., Grand Rapids.



MRS. R. E.  
SCRAFFORD

Your President attended the board meeting of the National Auxiliary at Chicago, November 11. Following that she called the mid-winter meeting of our State Board at Detroit, November 18.

At this time I wish to urge all County



Treasurers to have your National and State dues in as soon as possible. Dues for the State Treasury are 75c and for the National 25c. County Treasurers should have this money in the hands of the State Treasurer by March 3, 1939. That is the deadline.

As soon as the supplies come from the National office, the County Treasurers will be forwarded their supplies. In the meantime proceed to collect your dues. Your State officers will appreciate your coöperation in this regard, as our expenditures were unusually high this past year, and we also wish to maintain our good record with the National Auxiliary.

Cordially yours,  
(Mrs. R. E.) HELEN SCRAFFORD,  
*Secretary-Treasurer.*

#### Calhoun County

The Woman's Auxiliary of the Calhoun County Medical Society met for a coöperative dinner on Tuesday, October 4, at the home of Mrs. C. W. Brainard. Following dinner a business meeting was held. Reports of the State Auxiliary Meeting were given by Mrs. C. G. Wencke and Mrs. L. R. Keagle. The Chairman of each committee discussed her plans for the year. The Hygeia Chairman was asked to contact all the smaller schools in the county with a view of placing in each one a complimentary subscription for one year to Hygeia. A committee is also investigating possible projects for the Auxiliary to undertake. Since our last meeting in June we have donated to the new Community Hospital a unit of seven wheel chairs.

MRS. TH. KALVOORD,  
*Press Chairman.*

#### Jackson County

Mrs. Glen Hicks, a member of the Jackson Auxiliary, who retired this September as state president of the Woman's Auxiliary, was the main speaker of the evening. She gave us many interesting facts about the national Auxiliary convention held in California this summer. She said Kentucky leads in having the most active Woman's Auxiliaries in the country. To our delight, she then talked very informally about some of her personal experiences on this trip.

Dr. Philip A. Riley presented the pending legislative measures that were approved at the recent state medical meeting held in Detroit. He especially mentioned those measures based on socialized medicine. He stated that Jackson, Calhoun, and Washtenaw Counties have far more hospital beds than needed at present.

Mr. Hall, of the City Commission, talked to us about the necessity of a city charter revision, our Jackson charter being adopted 24 years ago.

Mrs. R. H. Alter, president, conducted a short business meeting, at which time reports were read by the secretary and the treasurer.

The meeting was held Tuesday evening, October 18, at the home of Mrs. W. E. McGarvey. Dinner was served by the committee which consisted of Mesdames E. F. Lewis, chairman, R. J. Hanna, J. W. Wholihan, W. B. Anderson, Frank Van Schoick, and John Ludwick.

(Mrs. A. M.) ANNA HYDE SHAEFFER,  
*Press Chairman.*

#### Kalamazoo

Mrs. L. N. Upjohn entertained members of the Woman's Auxiliary to the Academy of Medicine at a coöperative dinner on October 18. This was the first fall meeting. Thirty-five members responded to roll call.

New officers for the year are: President, Mrs. F. M. Doyle; president-elect, Mrs. Ralph Cook; vice president, Mrs. Sherman Gregg; secretary, Mrs. L. J. Crum; treasurer, Mrs. W. D. Irwin.

The following committee chairmen were appointed: Legislative, Mrs. F. T. Andrews; public relations, Mrs. Walter Den Bleyker; social-program, Mrs. W. O. Jennings; Hygeia, Mrs. Keith Bennett; membership, Mrs. John MacGregor; calling, Mrs. I. W. Brown, and publicity, Mrs. Hugo Aach.

(Mrs. Hugo) BARBARA K. AACH,  
*Publicity Chairman.*

#### Kent County

Dr. Ruth Herrick, chairman of the Division of Dermatology and Syphilology of the Michigan State Medical Society, gave a most interesting talk on the "The New Social Hygiene Program," at the year's first meeting of the Woman's Auxiliary to the Kent County Medical Society. Basing her talk on Syphilis, Dr. Herrick said, "Syphilis is a simple germ disease whose germ spirochete is a human parasite that can only survive at human body temperature. In addition to the changing social viewpoint on the disease, Dr. Herrick outlined treatment, discussed congenital syphilis and quoted from Surgeon General Parran's book 'Shadow on the Land,' which contains much statistical information and includes among its statements that 'one adult in ten has had or still has syphilis'."

Among the most interesting activities planned for the year are those under the direction of the Hygeia committee. This committee not only has conducted a rummage sale during the past month but is now making plans for a Persian Tea to be given in January and a Carnival sometime during the spring.

The annual dinner dance took place Friday evening, October 28, at Kent Country Club and was quite a gala affair. Hallowe'en decorations were the keynote for this year's party and entertainment included not only dancing and cards, but also exhibitions of modern dances including the Big Yam.

MRS. CHARLES H. FRANTZ,  
*Press Chairman.*

#### Lapeer County

The Lapeer County Medical Auxiliary met on Friday evening, September 4, at the Hotel Barrett, Lapeer, for a dinner with the doctors. On account of the short notice the attendance was small and no business meeting was held. "Novelty" bridge rounded out the evening.

On Friday evening, October 28, the Auxiliary met with the President, Mrs. H. G. Merz. After a bountiful pot-luck supper, Mrs. Merz gave a report of the State Auxiliary meeting at the Book-Cadillac, Detroit. Every one brought a "white elephant" to be used as a prize in the "medical" games which followed the business meeting. Mrs. John McBride extended an invitation to the members for a pot-luck supper at her home at North Branch in November.

MRS. D. J. O'BRIEN, *Reporter.*

Freddy—There certainly are a lot of girls in our town who do not wish to get married.

Sammy—How do you know?

Freddy—I've asked 17 of them already.

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# MICHIGAN'S DEPARTMENT OF HEALTH

DON W. GUDAKUNST, M.D., Commissioner  
LANSING, MICHIGAN

## ADVISORY COMMITTEE APPOINTED

An Advisory Committee for the Expansion of Public Health Activities in Michigan has been appointed by Governor Frank Murphy. Members of the committee will include Dr. Henry A. Luce of Detroit (chairman), Dr. Edward J. O'Brien of Detroit, Dr. Henry F. Vaughan of Detroit, Dr. Cyrus Sturgis of Ann Arbor, William J. Scripps of Detroit, Louis J. Nims of Lansing and Paul de Kruif of Holland.

The committee will serve in an advisory capacity to the Governor and the State Health Commissioner as to the methods of expanding the public health program. It will act as the main steering committee to put into operation the plans advanced at the Conference on Public Health held in Lansing September 10. This committee will have the assistance of subcommittees dealing with the problems of building diagnostic centers, legislative matters and expansion of personnel engaged in public health work.

"It is my hope," said Governor Murphy, "that this committee will be able to mobilize the forces of this state in such a manner that our health agencies and private physicians bring about a notable decrease in the preventable diseases and deaths of the state and thereby effect a vast saving in the cost of sickness."

## SCHOOL HEALTH EDUCATION PROGRAM

The Curriculum Steering Committee, acting in an advisory capacity to the Michigan Department of Public Instruction, has taken a significant step toward a more effective instructional program in health in the public schools. The committee has accepted health education as a fundamental factor in the far-reaching reorganization of the Michigan curriculum program now being carried on by the Department of Public Instruction.

Following a conference with health education leaders, Superintendent Eugene B. Elliott has appointed an exploratory committee which will recommend a program of health education to be carried on through the schools of Michigan. Members of this Exploratory Committee on Health Education include Dr. Mabel Rugen, Ann Arbor (chairman); Dr. Vaughn S. Blanchard, Detroit; Miss Marjorie Delavan, Lansing; Dr. Kenneth Easlick, Ann Arbor; Miss Alice Evans, Detroit; Dr. M. R. Kinde, Battle Creek; Chester F. Miller, Saginaw; James Ten Brink, Muskegon; Miss Grace Ryan, Mt. Pleasant; G. Robert Koopman, Lansing (secretary).

The first meeting of this committee was held October 31. The group expects to prepare a statement of general policy and functions of the various contributing agencies for the next meeting of the Curriculum Steering Committee.

## MORTALITY DECREASING

Mortality reports for the first nine months of 1938 compiled by the Bureau of Records and Statistics show a decline in total deaths from 40,572 in 1937 to 37,402 this year. Infant mortality, too, is down from 3,346 in 1937 to 3,187 in 1938. Maternal deaths slightly exceed last year's figures when an all-time low rate for this cause was set. There

were 249 maternal deaths last year compared to 360 this year. Births have increased from 68,889 in 1937 to this year's total of 72,260 for the nine month period.

Comparative mortality figures for the major communicable diseases in 1937 and 1938 are indicated in the accompanying table.

COMMUNICABLE DISEASE MORTALITY  
1937-1938

Disease	Sept. 1938	Sept. 1937	9 Months 1938	9 Months 1937
Pneumonia	136	155	2,053	3,129
Tuberculosis	146	151	1,467	1,656
Typhoid Fever	2	3	19	23
Diphtheria	2	8	28	45
Whooping Cough	15	17	94	105
Scarlet Fever	3	4	71	124
Measles	0	0	96	8
Smallpox	0	0	0	1
Meningitis	3	4	16	35
Poliomyelitis	3	18	7	43
Syphilis	30	25	278	298
Gonorrhea	0	2	6	7

## PERSONNEL

Dr. Clair E. Folsome, field consultant in obstetrics for the Michigan Department of Health, has been invited to speak at the New England Regional Maternal and Child Health Conference November 16, at Providence, R. I. The invitation was extended by Dr. Edwin F. Daily, director of the Division of Maternal and Child Health, Children's Bureau, who declared that Michigan's program in this field is outstanding. Dr. Folsome's services are available to local medical societies upon request. His schedule until January 1 will take him to Newaygo, Oceana, Ionia and Montcalm counties.

Dr. Georgia V. Mills of Detroit, a graduate of the Wayne University College of Medicine, has been attached to the staff of the Bureau of Maternal and Child Health as field physician. Dr. Mills will conduct women's health classes and at present has been assigned to Tuscola County.

Dr. Pearl Toivonen, formerly field physician for the Michigan Department of Health, has accepted an offer to become director of the Ontonagon-Baraga District Health Department. Dr. Toivonen's headquarters will be at Ontonagon.

Dr. Philip Bourland, until recently attached to the Department's Bureau of Epidemiology, has resigned to accept a position as director of the Dickinson County Health Department with headquarters at Iron Mountain.

## DISTRIBUTION OF ANTIPNEUMOCOCCIC SERUM

The Michigan Department of Health is now producing and distributing antipneumococcic serum to physicians free of charge for treating patients having Type 1 or Type 2 pneumonia. Physicians may obtain this serum upon request without regard to the indigency of the patient, the time interval between onset of the disease and beginning of treatment or the total amount of serum used in treating any case or the place of treatment.

In order that this serum may be used most effectively, however, certain procedures have been established by the Department as to typing of cases, distributing stations and physicians' reports. A booklet describing recommended procedures in the clinical use of antipneumococcic serum is also being prepared by Dr. A. E. Price of Detroit and will soon be available for physicians. Procedures estab-

lished by the Department for the distribution and use of anti-pneumococcic serum as well as the registered laboratories making pneumococcus type determinations are indicated below.

### Registered Typing Station

Michigan law requires that all laboratories doing communicable disease laboratory work be registered with the Michigan Department of Health Laboratory. It is only on the basis of typing done by such registered laboratories that distributing stations may distribute state antipneumococcic serum to physicians.

A registered typing station examines the material submitted for typing. In the event the pneumonia is found to be caused by one of the types for which serum is available, the "Receipt for Serum" form is filled out in triplicate, one copy being retained by the typing station, the other two being given the physician.

Antipneumococcic serum is available to physicians from serum distributing stations only on the presentation of these receipts for serum completely filled out showing that the type of pneumococcus causing the pneumonia has been demonstrated by a *Registered Typing Station*.

### Serum Distributing Station

On the presentation of two "Receipt for Serum" forms completely filled out, the distributing station gives the physician the serum receipted for, together with one or more copies of the "Case Report" form and an envelope for submitting one copy of the case report to the Michigan Department of Health. (In counties having full-time county or district health departments, these reports may be routed through the county or district health officer.) In order to be eligible for serum, a physician must complete and return to the Michigan Department of Health a case report covering each case treated with state serum within one month of the onset of pneumonia.

One copy of the receipt for serum is kept by the distributing station for its own files, the other returned to the Michigan Department of Health in envelopes provided for the purpose. (Where county or district health departments are acting as distributing stations, substations established to facilitate the distribution of serum will turn these over to the county or district health department, which in turn will send them on to the Michigan Department of Health.)

This receipt for serum when received by the Michigan Department of Health constitutes an order for additional serum in the amount shown on the receipt as having been distributed, and is the only basis on which serum will be sent out for replenishing the supply of a distributing station.

A "Receipt for Serum" form marked "Returned Outdated" and showing the amount and type of serum returned should be sent to the Michigan Department of Health to cover such serum as has to be returned, and will constitute an order for a like amount of serum.

### Physician

Within one month of the onset of pneumonia in the patient for whom serum has been obtained, the physician must submit a case report on the form provided for this purpose to the Michigan Department of Health. (These reports may be routed through a county or district health officer where a county or district health department has been established.)

There are no restrictions placed on the use of state antipneumococcic serum by the State Department of Health with regard to indigency, time interval between onset of illness and beginning of



## EDUCATION

Physicians who teach correct bowel management to their patients will appreciate the value of the new "Habit Time" booklet as a means of impressing patients with the importance of bowel regularity.

"Habit Time," written for doctors' patients in a clear, interesting style, embraces a discussion on diet, exercise and bowel regularity, in addition to a simple explanation of the functions of digestion.

"Habit Time," illustrated by Tom Jones, celebrated anatomical artist, has been reviewed and found satisfactory by the Council on Pharmacy and Chemistry of the American Medical Association. It is offered, free, by Petrolagar as an aid to doctors.

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65 cc. emulsified with 0.4 Gm. agar  
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### ANNOUNCES CONTINUOUS COURSES

**MEDICINE**—Personal Courses and Informal Course starting every week. Two Weeks Course in Internal Medicine starting June 5, 1939.

**SURGERY**—General Courses One, Two, Three and Six Months; Two Weeks Intensive Course in Surgical Technique with practice on living tissue; Clinical Courses; Special Courses. Courses start every Monday.

**GYNECOLOGY**—Two Weeks Course starting February 27, 1939. Clinical and Personal Courses starting every week.

**OBSTETRICS**—Two Weeks Intensive Course starting March 13, 1939. Informal Course starting every week.

**FRACTURES & TRAUMATIC SURGERY**—Informal Course every week; Intensive Ten Day Course starting February 13, 1939.

**OTOLARYNGOLOGY**—Two Weeks Intensive Course starting April 10, 1939. Informal Course starting every week.

**OPHTHALMOLOGY**—Two Weeks Intensive Course starting April 24, 1939. Informal Course starting every week.

**CYSTOSCOPY**—Ten Day Practical Course rotary every two weeks.

**GENERAL, INTENSIVE AND SPECIAL COURSES  
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treatment, total amount of serum used in any given case, nor place of treatment.

### Registered Laboratories in Michigan Making Pneumococcus Type Determinations

<i>Adrian</i>	Fairview Sanatorium
Emma L. Bixby Hospital	Florence Crittenton Hospital
<i>Albion</i>	Grace Hospital
J. W. Sheldon Memorial Hospital	Harper Hospital
<i>Ann Arbor</i>	Havers Laboratory
Department Pediatrics and Infant Diseases	Henry Ford Hospital
St. Joseph's Mercy Hospital	Jordan Clinical Laboratory
University Health Service	Marr General Hospital
University Hospital	Medical Clinical Laboratory
<i>Battle Creek</i>	Nottingham Clinical Laboratory
City Health Department	Owen Clinical
Chemical and Bacteriological Laboratory	Parkside Hospital
Community Hospital	Physicians Service
Battle Creek Sanitarium	Providence Hospital
L. Y. Post Montgomery Hospital	Receiving Hospital
<i>Bay City</i>	St. Joseph's Mercy Hospital
City Health Department	St. Mary's Hospital
Hess Clinical Laboratory	Shurly Hospital
Jones Clinic	Stafford Biological Laboratory
Merey Hospital	Trinity Hospital
Gamble Clinical Laboratory	Woman's Hospital
General Hospital	<i>East Lansing</i>
<i>Benton Harbor</i>	Michigan State College
Clinical Laboratory, Merey Hospital	<i>Eloise</i>
<i>Coldwater</i>	Seymour Hospital
Branch County Medical Laboratory	<i>Flint</i>
<i>Dearborn</i>	City Health Department
Dearborn Clinical Laboratory	Hurley Hospital
<i>Detroit</i>	St. Joseph Hospital
City Health Department	Zimmerman
Alexander Blain Hospital	<i>Grand Rapids</i>
Central Laboratories	Western Michigan Division,
Clark Clinical	Michigan Department of Health
Chas. G. Jennings Hospital	Allergic and Clinical Laboratory
Children's Hospital	Blodgett Memorial Hospital
Delray General Hospital	Butterworth Hospital
Detroit X-Ray and Clinical	St. Mary's Clinical Laboratory
Downtown Clinical	<i>Grosse Pointe</i>
East Side General Hospital	Cottage Hospital
Edyth K. Thomas Memorial Hospital	Nottingham Clinical Laboratory
Ellwart Clinical	<i>Hamtramck</i>
Evangelical Deaconess Hospital	Hamtramck Health Department
<i>Hastings</i>	St. Francis Hospital
Pennoek Hospital	

### Socialized Medicine Ruled Out in California

California's laws do not permit socialized medicine by private corporations, the State Supreme Court ruled in a decision on file here today.

The court, in issuing a writ against the Pacific Health Corp., held that recognition for any "drastic" change in the social need for corporate medical practice "should come from the legislature."

"A corporation may not engage in the practice of such professions as law, medicine or dentistry," the decision stated.—*Detroit News*, Sept. 3, 1938.

### "Isms"

Socialism means that if you have two cows, you give one to your neighbor. Under Communism you give both cows to the Government, which gives you back some of the milk. Under Fascism you keep the cows but give the milk to the Government, which sells you some of it back. And under New Dealism you shoot one cow, milk the other and then pour the milk down the sink!—*Detroit Free Press*, November 14, 1938.

## ◆ General News and Announcements ◆

Harold W. Wiley, M.D., of Lansing, addressed the members of the Eaton County Medical Society at its meeting of November 10. His subject was "Prenatal Care."

\* \* \*

A *One-man Mumm Show* was staged by Fred B. Miner, M.D., of Flint, on November 13, 1938, at his home. Doctor Miner has several unusually beautiful varieties in his collection.

\* \* \*

The Bay County Medical Society inserted an advertisement in the local newspapers asking the citizens of Bay County to contact the Secretary if they were unable to obtain necessary medical and dental care.

\* \* \*

Irvin Abell, M.D., president of the American Medical Association, has been awarded the Laetare medal by the University of Notre Dame. Doctor Abell is the seventh member of the medical profession to receive this award in the past fifty-six years.

\* \* \*

E. W. Schnoor, M.D., Grand Rapids; I. W. Greene, M.D., Owosso; Chas S. Kennedy, M.D., Detroit; and Stanley W. Insley, M.D., Detroit, have been appointed to the Legislative Committee. Aaron D. Riker, M.D., Pontiac, has been appointed to the Preventive Medicine Committee.

\* \* \*

The annual *Beaumont Lectures* in connection with the Wayne County Medical Society will be given at the Art Institute, Detroit, on February 20 and 21, 1939. The Beaumont Foundation Committee has been very fortunate in securing Dr. Jesse G. M. Bullowa of New York as the lecturer for 1939. Dr. Bullowa will discuss the subject of "Prophylaxis and Pneumonia Therapy." These are timely subjects and every member of the Michigan State Medical Society is welcome to attend.

\* \* \*

*Crippled and Afflicted Child Commitments* for October, 1938:

Crippled Child: Total cases, 310, of which 73 went to University Hospital and 237 went to miscellaneous hospitals. From Wayne County, of the above 1 went to University Hospital, and 52 to miscellaneous hospitals, total of 53.

Afflicted Child: Total cases, 1,925, of which 242 went to University Hospital and 1,683 went to miscellaneous hospitals. From Wayne County, of the above, 37 went to University Hospital, and 392 went to miscellaneous hospitals, total of 429.

\* \* \*

Talks given by the Michigan State Medical Society officers and the Executive Secretary include the following:

Speaker	City	Date	Organization	Subject
H. A. Miller LeMoyne Snyder	Stanton	November 4	Ionia-Montcalm Med. Soc.	"Legislative Activity"
Wm. J. Burns		November 7	Men's Community Club	"Budget Plans for Hospital and Medical Care"
Wm. J. Burns	Bay City	November 9	Woman's Auxiliary to the Bay County Medical Society	"Socialized Medicine"
L. Fernald Foster	Cass City	November 15	Rotary Club	"Federal Plans for Medical Care"
Robert S. Breakey	Ionia	November 29	Ionia Boy Scouts	"Venereal Diseases"

Ferris N. Smith, M.D., and O. H. McConnell, D.D.S., were guest speakers at the Ionia-Montcalm Medical Society meeting of November 10, held in Belding. Doctor Smith's subject was "Some Plastic Procedures About the Face of Interest to General Practitioners" and Doctor McConnell spoke on "Management of Jaw Fractures."

\* \* \*

*Warning!* A graduate from a school of limited practice has been attempting to gain admission to a hospital as an interne on credentials which credit him with an M.D. degree. If you hear of any person calling himself "Baum" who applies for internship, be sure his credentials are carefully investigated.

\* \* \*

The *Eighteenth Annual Public Health Conference* was held in Grand Rapids on November 9, 10, 11. The sessions were well attended by many physicians from all parts of the state. The Conference Program was under the direction of the Michigan Department of Health and the Michigan Public Health Association.

\* \* \*

The *Academy of Medicine at Cleveland* recently called a special meeting to discuss a definition of the "practice of medicine by hospitals." The Definition proposed by its Economics Committee reads as follows:

"A hospital shall be considered to be practicing medicine when it charges or collects a fee for the professional services of a physician; or for the interpretation of any procedure performed by a layman at the physician's order."

\* \* \*

The *St. Clair County Medical Society* held a Postgraduate Conference at Port Huron on November 8, with the following speakers: "The Heart in Middle Life" by E. D. Spaulding, M.D., of Detroit; "The Care of Acute Injuries" by Walter Maddock, M.D., and Robert Bartlett, M.D., of Ann Arbor; "The Management of Breech Presentation" by Howard H. Cummings, M.D., Ann Arbor. James D. Bruce, M.D., was the guest speaker at the dinner. His subject was "Postgraduate Education."

\* \* \*

Your advertising and exhibitor friends should have your whole-hearted and enthusiastic support. Why not remember to send that next order to one of the firms which carries its message in the M.S. JOURNAL or helped your State Convention to be really worthwhile? Here are the names of ten of the 1938 Technical Exhibitors:

Detroit X-Ray Sales Company, Detroit, Michigan.  
 Dictaphone Sales Corporation, Detroit, Michigan.  
 Duke Laboratories, Inc., Long Island City, New York.  
 General Electric X-Ray Corporation, Chicago, Illinois.  
 Gerber Products Company, Fremont, Michigan.  
 Gordon Shoe Company, Detroit, Michigan.  
 Hack Shoe Company, Detroit, Michigan.  
 Hanovia Chemical & Manufacturing Company, Newark, New Jersey.  
 J. F. Hartz Company, Detroit, Michigan.  
 H. J. Heinz Company, Pittsburgh, Pennsylvania.





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and Hospitals of the A. M. A.

"Medical Memoirs of Fifty Years in Kalamazoo" by Dr. Rush McNair of Kalamazoo will soon be issued from the press. The volume contains Dr. McNair's personal reminiscences of the doctors affiliated with the Kalamazoo Academy of Medicine since 1887. The work will contain over 90 pages and will review the lives of one hundred physicians of earlier years. It is announced as a limited edition. Many of us are acquainted with Dr. McNair's fine literary style, having already read a few of the sketches, and we have every confidence that the book when it appears, will do justice to the author's subject.

\* \* \*

The Ionia-Mountcalm Medical Society was host on Friday, November 4, at a dinner in honor of Senator D. Hale Brake, Stanton, Representatives Arthur Royce, John Smith, and Walter G. Herrick. The meeting was attended by forty medical and dental practitioners, members and guests of the Society.

Vernor M. Moore, M.D., Grand Rapids, Councilor of the Fifth District, presided, and a very interesting and informative program was presented by the guests of honor, with Doctors Lemoyne Snyder and Harold A. Miller of Lansing, A. V. Wenger of Grand Rapids, and Roy H. Holmes of Muskegon.

I. S. Lilly, M.D., of Stanton, was in charge of arrangements.

\* \* \*

The Radio Committee of the MSMS, in collaboration with the Joint Committee on Health Education, sponsored the following radio programs during the month of November:

Nov. 1—What to Do When Burned (Dialogue)—  
Chas. N. Weller, M.D.  
G. C. Penberthy, M.D.

Nov. 7—Asthma S. J. Levin, M.D.

Nov. 14—Conservation of Hearing (Questions and  
Answers)— Wm. S. Gonne, M.D.

Nov. 21—Diseases of the Skin in Relation to General Health— Harther L. Keim, M.D.

Nov. 28—The Significance of Bleeding from the  
Lower Intestinal Tract—  
L. J. Hirschman, M.D.

\* \* \*

A "State Society Night" program was held by the Muskegon County Medical Society on November 18, in Muskegon. President Charles A. Teifer opened the meeting and turned the program over to Roy H. Holmes, M.D., Councilor of the 11th District. I. W. Greene, M.D., Owosso, Councilor of the 6th District, addressed the meeting on "Medical Care Plans." P. R. Urmston, Chairman of The Council, spoke on "Group Hospitalization and Need for an Enabling Act." "Form 1-F of the A.M.A. Survey" was discussed by L. E. Holly, M.D., and Geo. LeFevre, M.D., both of Muskegon. President-Elect Burton R. Corbus discussed "Things in the Future for Medicine and Education of the Public." "The Speakers Bureau and Services of the Michigan State Medical Society to its members and the Public" was the subject of Secretary L. Fernald Foster. Wm. J. Burns discussed "Medical Care to the Indigent."

Chairman Holmes also called upon E. F. Sladek, M.D., Councilor from the 9th District; A. S. Brunk, M.D., Councilor of the 16th District, and Vernor M. Moore, M.D., Councilor of the 5th District.

\* \* \*

On Sunday, October 30, the *Detroit Free Press* carried a medical section. The first medical section in a Detroit daily paper was that published by the *Detroit Free Press* in 1937. The front page of the 1938 medical section contains clippings of medical news items over which is a globe of the world and the heading, "Medicine Moves Forward

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with the World." There are a number of signed articles and a larger number anonymous, except that they are written by the medical committee of contributors. The arrangement was accomplished by Mr. Lawrence Salter, formerly of the *Free Press* staff, now with the publicity department of the American Medical Association. Dr. Morris Fishbein, editor of the *American Medical Association Journal*, contributed an article on the services to the nation which are performed by the American Medical Association. The combined result is a newspaper section that was doubtless widely read by the *Free Press* readers. The venture was a credit to the Wayne County Medical Society, as well as the *Detroit Free Press*, which for a century or more has led as sponsor of the worthwhile in service to its large community.

\* \* \*

#### American Medical Association—Scientific Exhibit

Application blanks are now available for space in the Scientific Exhibit at the St. Louis Session of the American Medical Association, May 15-19, 1939. Attention is called to the fact that the meeting is a month earlier than usual, and applications close January 5, 1939. Blanks will be sent on request to the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn St., Chicago, Ill.

\* \* \*

#### Mid-Western Radiologists Meet

The Mid-Western Radiologists will convene for a clinical conference in Detroit, on February 10 and 11. The meeting place will be the Hotel Book-Cadillac. The program usually presented at these meetings consists chiefly of subjects of clinical importance with roentgenologic features. All of the

details of the program have not been arranged at this time, but a preliminary program will be announced in the near future.

\* \* \*

#### American Board of Obstetrics and Gynecology

The next written examination and review of case histories for Group B candidates will be held in various cities of the United States and Canada on Saturday, February 4, 1939, at 2:00 P. M. Application for admission to this examination must be filed on an official application form in the office of the Secretary at least sixty days prior to this date, (or before December 4, 1938).

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in St. Louis, Missouri, on May 15 and 16, 1939, immediately prior to the annual meeting of the American Medical Association. Application for admission to Group A examinations must be on file in the Secretary's Office by March 15, 1939.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Penn.

\* \* \*

#### Dr. Henry Luce

The *Muskegon County Medical Bulletin* recently published the following, descriptive of a splendid pen portrait of the president of the Michigan State Medical Society by the Muskegon County Medical Society's versatile artist, Dr. C. L. A. Oden. Dr. Oden is an exceptional artist and his interesting pen sketches of celebrities and near celebrities (we are not saying who the latter are) of Michigan Medicine have been an interesting feature of the *Bulletin* for the past year or so. We accuse our friend,



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1. Holmes and Deuel: Am. Jrl. Physiol., Vol. 54, P. 479. (Confirmed in experiments with New Nucoa by university workers.)

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2. Munsell, Jrl. A. M. A., Vol. 111, P. 250, 1938.

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Dr. Roy H. Holmes, of the write-ups. As an editor, Dr. Holmes is fearless, saucy and independent—all interesting characteristics of editorship.

Here goes.

"The cover this month (of the November *Muskegon County Medical Bulletin*) carries Dr. Oden's conception of our new State President, Henry Luce. Dr. Luce is making every possible effort to attend our State meeting, but as yet we can't be assured of his personal presence. If we were sure that Dr. Luce was not coming, we would dig out our dictionary and look up the words which appropriately describe the admiration and respect by his colleagues. His psychiatric training has come into good stead in his handling some of us crack-pots who might upset the proverbial applecart. How he can make each one of us feel that we are vitally important to the Society and his most trusted advisor, and then go ahead and do it his own way, is beyond the ken of ordinary mortal. Suffice it to say, as a testimonial to the delegates' belief in his capabilities, that when it was announced that Henry Luce would be a candidate for President-Elect, no one would even consider placing their name in nomination against him. We hope that he is able to attend our meeting, and that you will have another opportunity to meet one of the grandest men in Michigan medicine."

## CORRESPONDENCE

### ATTORNEY GENERAL'S OPINION ON CHIROPRACTORS' STATUS

August 23, 1938

State Board of Registration in Medicine,  
100 West Allegan Street,  
Lansing, Michigan.

GENTLEMEN:

We are in receipt of your recent letter requesting the opinion of this office in regard to the status of chiropractors under the laws of Michigan, with particular reference to an *attached brief of argument and legal authority*.

The brief purports to define "chiropractic" under the Michigan law, and analyzes the legal authority in support of the propositions that a chiropractor cannot legally furnish medical and surgical services contemplated by the Workmen's Compensation Act, and that a chiropractor cannot lawfully use the title "doctor" or its abbreviation.

*It is our opinion, without adopting the language in the argument of this brief, that the conclusions therein stated are correct upon the above propositions.*

"Chiropractic" is defined in Section 6 of Act No. 145, Public Acts of 1933, to be "the locating of misaligned or displaced vertebræ of the human spine, the procedure preparatory to and the adjustment by hand of such misaligned or displaced vertebræ and surrounding bones or tissues." The word "chiropractic" is limited in scope, as above specified, and a chiropractor is not entitled to designate himself as a "physician" by reason of his license to practice "chiropractic." *New York Life Insurance Co. v. Modzelewski*, 267 Mich. 293.

A chiropractor who engages in treating ailments or diseases by any method not chiropractic, or ailments and diseases which cannot be treated or corrected by chiropractic methods, is engaged in the unauthorized practice of medicine contrary to Act No. 237, Public Acts of 1899, as amended, particularly Sections 7 and 9 thereof, being Sections 6743 and 6745, Compiled Laws of 1929. See *State v. Boston* (Iowa), 278 N. W. 291; *State v. Stoddard* (Iowa), 245 N. W. 273; *State v. Lyndon* (Wash.), 16 Pac. (2nd) 848; *People v. Machado* (Cal.), 279 Pac. 228.

It is also our opinion that chiropractors are not authorized to give medical treatment to persons injured by industrial accidents, or incapacitated by occupational diseases, under the Michigan Work-

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men's Compensation Law, as amended, being Act No. 10, Public Acts of 1912 Extra Session, as last amended by Act No. 61, Public Acts of 1937, and Act No. 3, Public Acts of 1937 Extra Session.

The medical services contemplated by Sections 4 and 19 of the Michigan law, being Sections 8420 and 8435, Compiled Laws of 1929, are not services which can be performed by a chiropractor; and an employer furnishing the services of a chiropractor to his injured or diseased employees is not discharging his duty to his employees under the said act. See *Golden's Case* (Mass.), 132 N. E. 726; *Carsten v. State Industrial Commission* (Wis.), 240 N. W. 834; *Joyner v. State* (Miss.), 179 So. 573.

As this office has previously ruled, a chiropractor does not have legal authority to use the prefix or abbreviation "doctor," or "Dr." before his name; and his use of the title or abbreviation in a medical sense is a violation of the Medical Practice Act. See *State Board of Medical Examiners v. DeYoung* (N. J.), 140 Atl. 676; *State v. Michels* (Wis.), 277 N. W. 157.

We trust that the foregoing satisfactorily answers your questions.

Very truly yours,

RAYMOND W. STARR,  
Attorney General.

By JOHN H. BRENNAN,  
Deputy Attorney General.

## Among Our Contributors

### OUR CONTRIBUTORS

Dr. Joseph Louis Baer is Professor of Obstetrics and Gynecology, Rush Medical College; Senior Attending Gynecologist and Attending Obstetrician, of the Michael Reese Hospital. He is a Fellow of the American Board of Obstetrics and Gynecology; a member of the Institute of Medicine, Chicago, the American Gynecological Society, the Board of Directors of the Infant Welfare Society, Chicago.

\* \* \*

Dr. J. Arnold Barga of Rochester, Minnesota, is Associate Professor of Medicine at the Mayo Foundation, consultant in Medicine at the Mayo Clinic, and is in charge of Intestinal Service, St. Mary's Hospital. Dr. Barga is a member of the American Gastro-Enterological Association, Central Society for Clinical Research, Pan-American Medical Association, and the International Gastro-Enterological Association.

\* \* \*

Dr. Oscar V. Batson received the degree of M.D. from St. Louis University in 1920. He was instructor in Anatomy, University of Wisconsin, 1920-21; Assistant Professor, Associate Professor and Professor of Anatomy, University of Cincinnati, 1921-28; Professor of Anatomy, Graduate School of Medicine, University of Pennsylvania, since 1928, and member of the staff of the Graduate Hospital, University Hospital and Philadelphia General Hospital. Dr. Batson is a member of the American Association of Anatomists and the American Academy of Ophthalmology and Otolaryngology.

\* \* \*

Dr. John Freedman is a graduate of the University of Michigan Medical School of the class of 1926. In 1930, he was Assistant in Roentgenology at Mt. Sinai Hospital, Milwaukee, Wisconsin; from 1931 to 1932, he was Assistant and Instructor in Roentgenology Research and Ed-



educational Hospital and College of Medicine of the University of Illinois. He is a diplomate of the American Board of Radiology, and is now in private practice, specializing in roentgenology.

\* \* \*

Dr. Raphael Isaacs was graduated from the University of Cincinnati College of Medicine in 1918. He was formerly Instructor in Medicine at Harvard Medical School and is now Associate Professor of Medicine and Assistant Director of the Simpson Memorial Institute for Medical Research, University of Michigan. Dr. Isaacs is carrying on research in hematology.

\* \* \*

Dr. E. O. Jodar was graduated from the University of Illinois in 1927 with B.S. and M.D. degrees. He was at Ford Hospital for two years and at the Children's Clinic Group for two years. Since 1931, he has limited his practice to Pediatrics with special reference to blood transfusions.

\* \* \*

Dr. Joseph Johns is a graduate of the American Medical Missionary College of Chicago in 1910. (This college merged with the University of Illinois-Chicago.) He received internship at Providence Hospital of Detroit in 1920; was Assistant of Clinical Surgery in Royal Infirmary of Glasgow in 1923; did post-graduate work at the Laboratory of Surgical Technic of Chicago in 1927. Mayo Clinic in 1929. He is Associate Surgeon in the Clinton Memorial Hospital, St. Johns, Michigan.

\* \* \*

Dr. Frank A. Kelly graduated from the Detroit Homeopathic College in 1903 and the University of Detroit in 1919. His specialty is general surgery. Dr. Kelly is Surgeon in Chief at Grace Hospital, Attending Surgeon, Evangelical Deaconess Hospital, and Consulting Surgeon of the Detroit Receiving Hospital, also the Highland Park General Hospital. Dr. Kelly is a special lecturer in surgery at the Wayne University College of Medicine.

\* \* \*

Dr. Irvin W. Sander is Director of the Student Health Service at Wayne University, Detroit, and Associate Professor of Preventive Medicine and Public Health. Graduate of Detroit College of Medicine and Surgery, 1929. Professor of Embryology, same, 1925-1936. Degree Dr.P.H., Wayne University College of Medicine, 1933.

\* \* \*

Dr. Fred J. Taussig was graduated A.B. from Harvard University in 1893, and M.D. from Washington University in 1898. In 1929, he was president of the Central Association of Gynecology and Obstetrics, and in 1937, he was president of the American Gynecological Society. Dr. Taussig was

gynecologist of the Barnard Free Skin and Cancer Hospital from 1906 to 1938. He is Professor of Clinical Obstetrics at the Washington University School of Medicine.

\* \* \*

Dr. Nina C. Wilkerson is a graduate of the University of Kansas School of Medicine, 1929. She is engaged in general practice at Sturgis, Michigan. At present, she is serving her third term as Health Officer of that city.

\* \* \*

Dr. Edward Wishropp was graduated from the University of Michigan Medical School in 1922. He received his B.S. from the same school in 1920. Dr. Wishropp was Resident Physician and Instructor in Pediatrics at Cornell Medical School, and the New York Nursery and Child's Hospitals, 1924-25. He was Resident and Instructor in Pediatrics at the University of California Medical School in 1926. He has specialized in Pediatrics in Detroit since 1927, and is an instructor in Pediatrics at Wayne University Medical School.

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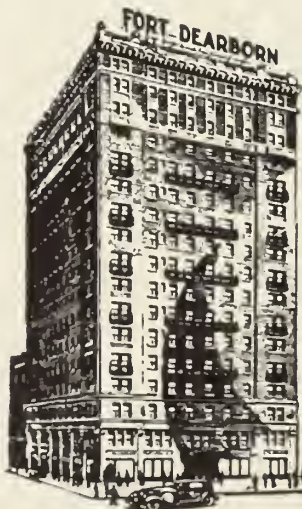
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## THE DOCTOR'S LIBRARY

*Acknowledgment of all books received will be made in this column and this will be deemed by us a full compensation to those sending them. A selection will be made for review, as expedient.*

**PATHOLOGICAL TECHNIQUE, A PRACTICAL MANUAL FOR WORKERS IN PATHOLOGICAL HISTOLOGY INCLUDING DIRECTIONS FOR THE PERFORMANCE OF AUTOPSIES AND FOR MICROPHOTOGRAPHY.** By Frank Burr Mallory, A.M., M.D., S.D. Consulting Pathologist to the Boston City Hospital, Boston, Mass. Illustrated, Philadelphia and London: W. B. Saunders Company, 1938.

The author does not offer this work as an encyclopedia covering the subject in its complete details. He has, instead, selected those methods and formulas that have been found of most value in the past and those which seem to offer the most value for the present. The work is intended to serve the needs of the hospital pathologist and of students and technicians as well as of practitioners who are interested in pathologic technics. For these it is a valuable addition to one's library.

**FEARFULLY AND WONDERFULLY MADE, THE HUMAN ORGANISM IN THE LIGHT OF MODERN SCIENCE.** By Renée von Eulenburg-Wiener. New York: The Macmillan Company, 1938.

This is a work on human physiology which also includes physiological chemistry. It presents the subject with great clarity and as completely as possible in 470 pages. It is an admirable book for the physician who wishes to review the whole field of physiology, and it will be found valuable likewise to the educated general reader whose interests are scientific, inasmuch as it would require a knowledge of chemistry to read it intelligently. It is printed on a high grade of paper with good legible

type. The illustrations, though not profuse, are line drawings which aid in the elucidation of the text. To repeat, as a means of reviewing the subject of physiology as a pastime, we know of no better book.

**BIG FLEAS HAVE LITTLE FLEAS, or Who's Who Among the Protozoa.** By Robert Hegner, Professor of Protozoology in the School of Hygiene and Public Health of the Johns Hopkins University, Based on Messenger Lectures, Cornell University, 1937. Baltimore: The Williams & Wilkins Company, 1938. Price: \$3.00.

Anyone familiar with Dean Swift's little verse,

Big fleas have little fleas  
Upon their backs to bite 'em,  
And little fleas have lesser fleas  
And so ad infinitum.

might guess what may be the subject of this book. For those who might spend too much time guessing, we haste to say that it is a work of 285 pages on protozoology, written by a master. It is as simple as the subject will permit, and with an occasional consultation of the glossary, the average person with a high school education should have no trouble in obtaining an intelligent understanding of the subject. It is more than a textbook. The very graphic, not to say facetious illustrations, are unique. The protozoa are made to talk and carry on dialogues. Not only has the author made use of pen illustrations in black and white—he has shown great facility in parodying some of the old familiar songs, for instance:

Forward little millions,  
Marching gaily on,  
Little naked 'meba,  
Leads the mighty throng.

Comes the green Euglena,  
And Paramecium too,  
Followed by the Spore Bearers,  
Cavorting two by two.

Onward little millions,  
Marching for to see  
If they cannot dominate  
The world, and you and me.

or

"Adventure lies over the ocean  
For pioneers craving to roam;  
But nature is swarming with microbes  
In Everyman's own home sweet home.

Get wise then to rat and to cockroach;  
Be gentle with guineas and geeses;  
Inside of their cute little tummies  
May flourish a cosmos of species."

As an example of his lucid style, we have his description of a parasite:

"The term Parasite when applied to human beings has much the same meaning as that recognized by biologists. Originally, it was used for persons who frequented the tables of the rich and earned their welcome by flattery. Parasitism in a restricted sense is now used only for the type of association between two different species of organisms in which one species, the host, is actually injured by the other species, the parasite. A parasite of this type is said to be pathogenic to its host. In a broad sense, Parasitism implies any condition in which one species lives in or on another species."

If one wishes to combine profitable with pleasurable reading, one cannot do better than to peruse "Big Fleas Have Little Fleas."

The Council on Physical Therapy of the American Medical Association has published a brochure of seventy-eight pages listing the apparatus accepted and approved by the council. This brochure not only lists the various apparatus but gives concise descriptions in many instances. The names of the firms manufacturing the various apparatus are also given. To those doctors including physical therapy in their practice, the little brochure should prove interesting.

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Alpena-Alcona- Presque Isle.....	W. E. NESBITT Alpena	HAROLD KESSLER Alpena	Last Thursday 6:00 p. m.	Last Thursday December
Barry .....	G. F. FISHER Hastings	THOMAS H. COBB Woodland	2nd Thursday 8:00 p. m.	1st Thursday January
Bay-Arenac-Iosco- Gladwin .....	C. L. HESS Bay City	A. L. ZILIAK Bay City	2nd and 4th Wednesday (ex- cept July, Aug., Sept.) 6:00 p. m.	2nd Wednesday December
Berrien .....	HARRY KOK Benton Harbor	A. F. BLIESMER St. Joseph	2nd Wednesday or Thursday	2nd Wednesday or Thursday, December
Branch .....	N. S. ALDRICH Coldwater	F. S. LEEDER Coldwater	3rd Thursday 6:30 p. m.	3rd Thursday December
Calhoun .....	J. E. ROSENFELD Battle Creek	WILFRID HAUGHEY Battle Creek	1st Tuesday (except July and Aug.)	1st Tuesday December
Cass .....	K. C. PIERCE Dowagiac	GEO. LOUPEE Dowagiac	2nd Wednesday or Thursday	December 15
Chippewa- Mackinac .....	J. F. DARBY St. Ignace	DWIGHT F. SCOTT Sault Ste. Marie	1st Thursday 7:30 p. m.	1st Thursday December
Clinton .....	F. E. LUTON St. Johns	T. Y. HO St. Johns	Last Tuesday (Oct. to June, incl.)	Last Tuesday October
Delta-Schoolcraft ...	W. A. LEMIRE Escanaba	G. W. BENSON Escanaba	1st Thursday 8:30 p. m.	December 2
Dickinson-Iron .....	L. E. IRVINE Iron River	W. H. HURON Iron Mountain	1st Thursday 6:30 p. m.	1st Thursday December
Eaton .....	BERT VAN ARK Eaton Rapids	THOMAS WILENSKY Eaton Rapids	3rd Thursday	No set date
Genesee .....	A. MCARTHUR Flint	C. W. COLWELL Flint	2nd and 4th Tuesday (ex- cept July and August)	2nd Tuesday November
Gogebic .....	CHAS. E. ANDERSON Bessemer	WM. H. WACEK Ironwood	3rd Tuesday	3rd Tuesday December
Grand Traverse- Leelanau-Benzie	MARK OSTERLIN Traverse City	C. E. LEMEN Traverse City	1st Tuesday 8:00 p. m.	1st Tuesday December
Gratiot-Isabella- Clare .....	C. M. BASKERVILLE Mt. Pleasant	RICHARD L. WAGGONER St. Louis	3rd Thursday	3rd Thursday December
Hillsdale .....	W. E. ALLEGER Pittsford	E. G. MCGAVRAN Hillsdale	Last Thursday	Last Thursday December
Houghton-Baraga- Keweenaw .....	R. S. BUCKLAND Baraga	C. A. COOPER Hancock	1st Tuesday	1st Tuesday January
Huron-Sanilac .....	R. R. GETTEL Kinde	E. W. BLANCHARD Deckerville	2nd Thursday	2nd Thursday December
Ingham .....	DANA M. SNELL Lansing	R. J. HIMMELBERGER Lansing	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Ionia-Montcalm ....	R. R. WHITTEN Ionia	JOHN J. McCANN Ionia	2nd Tuesday 7:00 p. m.	2nd Tuesday December
Jackson .....	JOHN VAN SCHOICK Hanover	H. W. PORTER Jackson	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kalamazoo- Van Buren .....	R. J. HUBBELL Kalamazoo	L. W. GERSTNER Kalamazoo	3rd Tuesday 6:30 p. m.	3rd Tuesday December
Kent .....	A. J. BAKER Grand Rapids	J. M. WHALEN Grand Rapids	2nd and 4th Wednesday 8:15 p. m.	2nd Wednesday December
Lapeer .....	G. C. BISHOP Almont	C. C. JACKSON Imlay City	2nd Thursday	December or January
Lenawee .....	CHAD A. VAN DUSEN Blissfield	ESLI T. MORDEN Adrian	3rd Tuesday	3rd Tuesday October
Livingston .....	BERNARD H. GLENN Fowlerville	DUNCAN C. STEPHENS Howell	1st Friday 6:30 p. m.	1st Friday December
Luce .....	A. T. REHN Newberry	C. D. HART Newberry	1st Tuesday 8:00 p. m.	1st Tuesday December
Macomb .....	JOSEPH N. SCHER Mt. Clemens	R. F. SALOT Mt. Clemens	1st Monday 12:00 noon	1st Monday December
Manistee .....	KATHRYN BRYAN Manistee	C. L. GRANT Manistee	Every Monday noon	1st Monday December
Marquette-Alger ....	N. J. McCANN Ishpeming	D. P. HORNBOKEN Marquette	No set date	December
Mason .....	V. J. BLANCHETTE Custer	CHAS A. PAUKSTIS Ludington	2nd Tuesday	2nd Tuesday December
Mecosta-Osceola ...	L. F. CRESS Reed City	GLENN GRIEVE Big Rapids	2nd Tuesday	2nd Tuesday December

# COUNTY SOCIETIES

Menominee .....	JOHN TOWEY Powers	WM. S. JONES Menominee	3rd Thursday	3rd Thursday December
Midland .....	CHAS. L. MacCALLUM Midland	N. C. GREWE Midland	2nd Thursday	2nd Thursday December
Monroe .....	W. J. GELHAUS Monroe	FLORENCE AMES Monroe	3rd Thursday (except July and Aug.)	3rd Thursday October
Muskegon .....	CHAS. A. TEIFER Muskegon	L. E. HOLLY Muskegon	Last Friday 6:00 p. m.	2nd Friday December
Newaygo .....	LAMBERT GEERLINGS Fremont	W. H. BARNUM Fremont	As called	3rd Tuesday December
Northern Mich. (Antrim- Charlevoix- Emmet- Cheboygan) .....	B. H. VANLEUVEN Petoskey	W. E. LARSON Levering	2nd Thursday 6:00 p. m.	2nd Thursday December
Oakland .....	AARON RIKER Pontiac	O. O. BECK Birmingham	1st Wednesday (except July and Aug.)	1st Wednesday December
Oceana .....	MERLE G. WOOD Hart	N. W. HEYSETT Hart	No definite date set	December
O.M.C.O.R.O. (Otsego- Montmorency- Crawford-Oscoda- Roscommon- Ogemaw) .....	LEVI A. HARRIS Gaylord	C. G. CLIPPERT Grayling	On call	December
Ontonagon .....	F. W. McHUGH Ontonagon	E. J. EVANS Ontonagon	On call	January
Ottawa .....	GERRIT KEMME Zeeland	D. C. BLOEMENDAL Zeeland	2nd Tuesday Noon	2nd Tuesday December
Saginaw .....	W. K. ANDERSON Saginaw	H. C. WALLACE Saginaw	3rd Tuesday 8:30 p. m.	3rd Tuesday December
Shiawassee .....	W. E. WARD Owosso	R. J. BROWN Owosso	3rd Thursday Noon	3rd Thursday December
St. Clair .....	C. A. MacPHERSON St. Clair	JACOB H. BURLEY Port Huron	1st and 3rd Tuesdays Oct. to June	3rd Tuesday December
St. Joseph .....	R. A. SPRINGER Centreville	JOHN W. RICE Sturgis	1st Thursday 6:30 p. m.	1st Thursday January
Tuscola .....	LLOYD L. SAVAGE Caro	R. R. HOWLETT Caro	2nd Thursday 8:00 p. m.	2nd Thursday November
Washtenaw .....	S. L. LAFEVER Ann Arbor	WM. M. BRACE Ann Arbor	2nd Tuesday	2nd Tuesday December
Wayne .....	HENRY R. CARSTENS Detroit	B. I. JOHNSTONE Detroit	Every Monday 8:45 p. m. (Oct. to May, incl.)	3rd Monday in May
Wexford- Kalkaska- Missaukee .....	B. A. HOLM Cadillac	MICHAEL R. MURPHY Cadillac	Last Thursday	Last Thursday October

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Vol. VIII

Detroit, Michigan, December, 1938

No. 12

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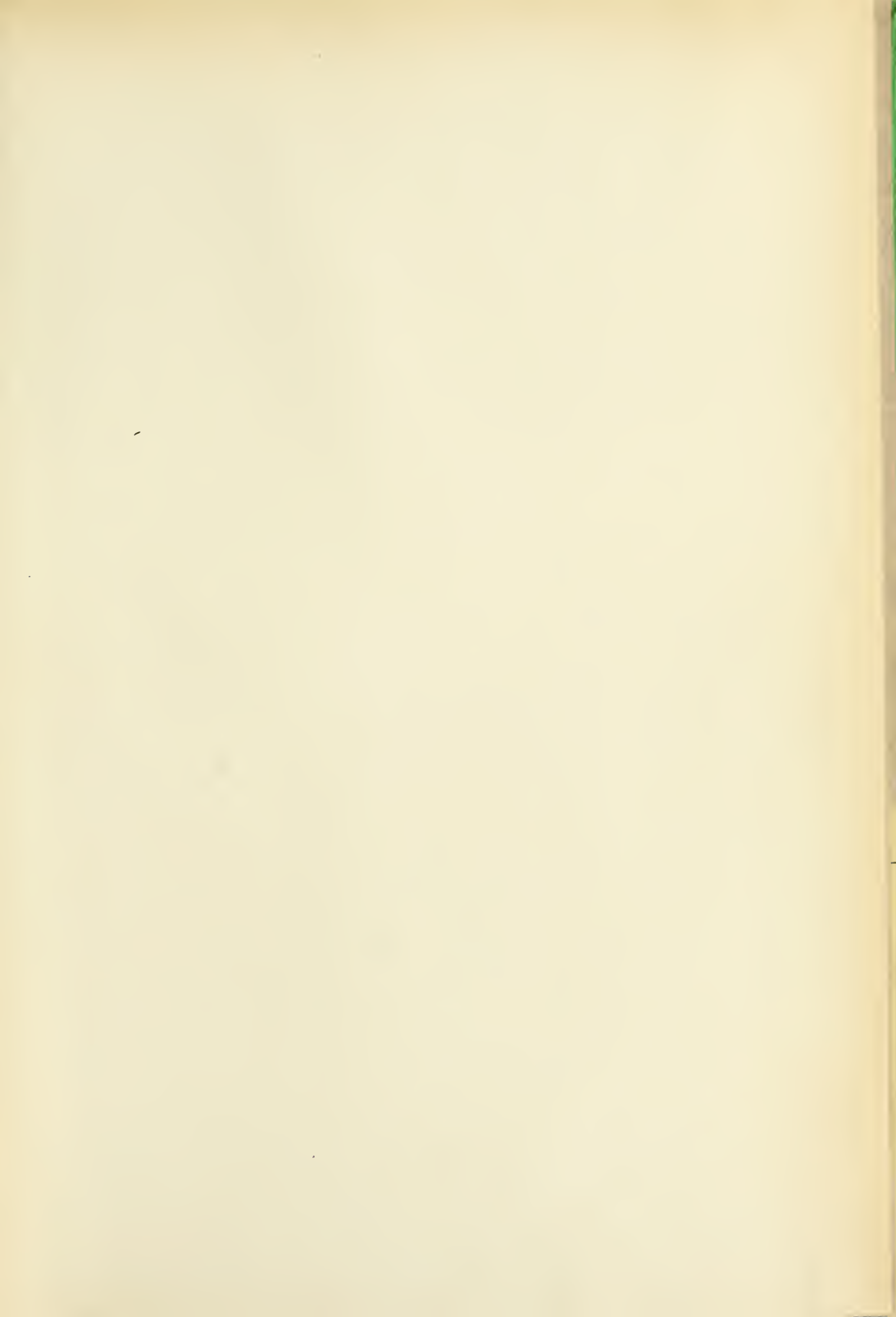
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